

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

PRINTED: 10/15/2014
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 10/02/2014
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 Recertification Survey was initiated on 09/30/14 and concluded on 10/02/14 and found the facility did not meet minimum regulatory requirements with deficiencies cited.	F 000			
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to convey upon death, the personal funds deposited with the facility to the individual or probate jurisdiction administering the individual's estate as provided by State Law for one (1) of five (5) unsampled resident accounts (Unsampled Resident A) and the twenty-three (23) sampled residents. The resident's trust fund balance deposited with the facility for Unsampled Resident A was applied to the resident's personal account balance and not conveyed to the legal representative. The findings include: Review of the facility's Administration of Resident Trust Fund policy, effective 05/17/13, revealed the policy of the facility was to administer resident funds entrusted to its safekeeping in accordance	F 160	1. The affected deceased resident identified as un-sampled Resident A was addressed as follows: The resident's POA was contacted concerning the conveyance of the balance remaining in the resident's trust. The POA provided written confirmation of his verbal directive on 5/15/14 to authorize the facility to offset the trust balance and apply the entire amount to the resident's outstanding A/R balance. 2. Other residents potentially affected by the identified issue were addressed as follows: a. A 100% audit of Resident Trust balance conveyance records for the prior six months was conducted by the Office Manager on 10/2/14. There were no other residents found to be affected by the issue. 3. The facility initiated the following corrective measures to ensure that the deficient practice will not reoccur as follows: a. The Administrator conducted in-service training with the Office Manager and the Assistant Billing Manager on the revised policy titled "Administration of Resident Trust Fund" on 10/16/14. See attachment F160 #1 In-service record		

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

X *Supreme Knie*

TITLE

X *Exp Dir Administration*

(X6) DATE

11/5/14

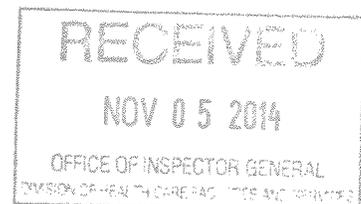
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

PRINTED: 10/15/2014
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 10/02/2014
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 160	<p>Continued From page 1</p> <p>with federal and state regulations concerning deposits, withdrawals, management accounting and security of the resident trust fund. Upon authorization from the resident or resident's representative, the facility would hold, safeguard, manage and account for the personal funds of the resident deposited with the facility. Upon death or discharge of the resident, personal funds would be conveyed within thirty (30) days with a final accounting to the individual or resident representative who administered the resident's estate.</p> <p>Review of the Resident Fund and Security Acknowledgment form for Unsampled Resident A revealed the form was signed 04/01/14, by the legal representative.</p> <p>Review of a check request, dated 05/22/14, revealed check #3862, dated 05/22/14, in the amount of four hundred fifty dollars and seventeen cents (\$450.17), identified the check was made to the facility and was written from Unsampled Resident A's closed trust account with payment applied to charges owed.</p> <p>Interview with the Office Manager Assistant/Billing, on 10/01/14 at 1:54 PM, revealed Unsampled Resident A was transferred to the hospital on 05/12/14 and expired on 05/13/14. The remaining trust funds were four hundred fifty dollars and seventeen cents (\$450.17). She stated the account was closed on 05/22/14. The account balance of four hundred fifty dollars and seventeen cents (\$450.17) was applied to the personal account balance. She stated, Unsampled Resident A had an outstanding balance of \$2285.58, yet to be paid. She stated, if the residents don't owe a balance,</p>	F 160	<p>b. The facility policy "Administration of Resident Trust Fund" was revised by the Administrator and approved by the QAPI Committee for approval on 10/16/14. See attachment F160 #2 Administration of Resident Trust Fund Policy</p> <p>c. The Administrator will approve and sign off on all refund checks effective 10/16/14</p> <p>d. Administrator and Office Manager developed an audit tool (QA B-13) Resident Trust Audit to track facility compliance with revised policy Administration of Resident Trust Funds.</p> <p>4. The facility has initiated the following plans to monitor performance to ensure that solutions are sustained as follows:</p> <p>a. The Office Manager will complete a monthly audit (B-13) on all Resident Trust Accounts of deceased residents to ensure a final accounting of those funds to the probate jurisdiction administering the residents estate</p> <p>b. The Administrator will be responsible to assure that the new quality indicator titled "Resident Trust Account Review QA B-13 is completed and submitted to the QAPI Committee monthly.</p> <p>c. The indicator will be reviewed by QAPI Committee monthly for six months to monitor the effectiveness of the compliance plan will assess revisions to monitoring schedules for continued compliance.</p>		

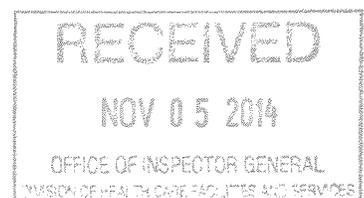
10-28-14
P. S. R.
11-7-14



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

PRINTED: 10/15/2014
FORM APPROVED
OMB NO. 0938-0391

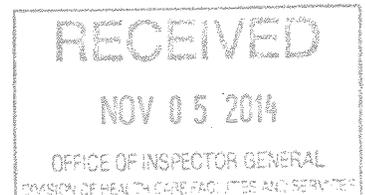
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/02/2014
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 160	Continued From page 2 then the refund is paid within thirty (30) days. If the residents have a balance the facility offers the family the option to apply the remaining funds to the balance. All refunds are applied to the outstanding balance unless it is noted other wise. Interview with the Office Manager, on 10/01/14 at 1:54 PM, revealed the family of Unsampled Resident A was provided the option to apply the resident's trust account balance to the outstanding account balance. The family told the facility to apply the balance account; however there was no evidence of this provided. Interview with the Administrator, on 10/02/14 at 2:20 PM, revealed the family was given the option for a refund or the monies be applied to the outstanding balance. She stated they were following the verbal directions of the family.	F 160			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure fifteen (15) of twenty (20) wheelchairs were maintained in a clean and sanitary manor in the Marsh Household. The findings include:	F 253	1. The affected residents identified as sampled Resident #12 and 14 and other wheelchairs on the same house were addressed as follows: The identified residents' wheelchairs were cleaned on 10/2/14. 2. To identify other residents potentially affected by the identified issue the facility addressed as follows: a. A 100% audit was completed on all the all facility wheelchairs on 10/3/14. Then, the wheelchairs were placed on a weekly cleaning schedule by the Director of Nursing. See attachment F253 #1 3. The facility initiated the following corrective measures to ensure that the deficient practice will not reoccur as follows:		



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

PRINTED: 10/15/2014
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 10/02/2014
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 253	<p>Continued From page 3</p> <p>Review of the facility's policy regarding Terminal Cleaning & Wheelchair Reassignment, revised January 2011, revealed routine cleaning of wheelchairs was managed by the nursing staff.</p> <p>Review of the Caregiver Duties inservice, dated 06/11/14 and 06/12/14, revealed wheelchairs would be cleaned on resident shower days during the night shift.</p> <p>Review of the Wheel Chair audit, dated 10/02/14, revealed a total of twenty (20) manual wheelchairs in the Marsh House.</p> <p>During the Resident Group Interview, on 09/30/14 at 2:00 PM, revealed Resident #12 stated his/her wheelchair had not been cleaned; however, did not identify for how long.</p> <p>Observation of Resident #12's wheelchair, on 09/30/14 at 2:00 PM, revealed a buildup of dust and loose brown particles on the frame under the seat and on the wheels.</p> <p>Observations of wheelchairs in the Marsh House during lunch, on 10/01/14 at 12:00 PM, revealed eight (8) of eight (8) wheelchairs contained dust and loose brown particles on the frame under the seat and on the wheels.</p> <p>Observation of seventeen (17) wheelchairs in the Marsh House, on 10/02/14 at 11:00 AM, revealed fifteen (15) wheelchairs had tan dust and particulars on the under carriage.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 10/02/14 at 10:35 AM, revealed the night shift was responsible for taking wheelchairs to the basement wheelchair cleaning room weekly for</p>	F 253	<p>a. The Director of Nursing and Administrator developed a facility policy titled "Wheelchair Cleaning and Maintenance" on 10/17/14. See attachment F253# 2</p> <p>b. The Director of Nursing revised the nursing assistant assignment sheet titled "Shower, Nail care, Laundry Flow Sheet" to include schedule for wheelchair cleaning and repairs on 10/17/14. See Attachment F 253 #3 Shower, Nail care, Laundry and Wheelchair Cleaning and Repairs Flow sheet.</p> <p>c. The Director of Nursing developed an audit tool QA N-57 to be documented by the Nurse leaders for the purpose of tracking the nursing assistant's completion of nightly flow sheet assignments on 10/17/14. See Attachment F253 #4 Nurse leader audit tool N -57</p> <p>d. The Director of Nursing and the Assistant Director of Nursing conducted an in-service to the nurse leaders, staff nurses and nursing assistants on the revised policy, flow sheet and audit protocol completed 10/27/14. See Attachment F253 #5 In-service form</p> <p>e. The Administrator in-serviced the Environmental Director on the revised policy "Wheelchair Cleaning and Maintenance on 10/22/14 See Attachment F253 #6 In-service form</p>	



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

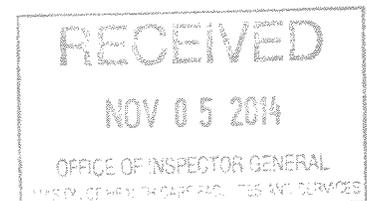
PRINTED: 10/15/2014
FORM APPROVED
OMB NO. 0938-0391

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 10/02/2014
--	--	--	--

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
--------------------	--	---------------	---	----------------------

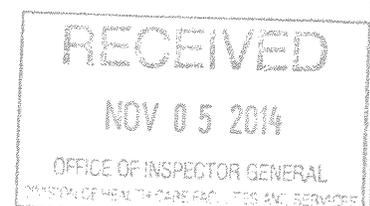
F 253	Continued From page 4 cleaning. Interview further revealed that there are usually two (2) CNA's on the night shift with one (1) CNA working on each of the two (2) hallways. Interview with Licensed Practical Nurse (LPN) #4, on 10/02/14 at 10:05 AM, revealed the night shift was responsible for routine wheelchair cleanings. She stated that a cleaning schedule existed, but was unsure of how often the schedule indicated to clean the wheelchairs. Interview with the House Lead, LPN #3, on 10/02/14 at 10:45 AM, revealed the wheelchair cleaning schedule was on the Care Giver Assignment Sheet. The LPN stated the policy was for third (3rd) shift staff to clean the wheelchairs on the same night that resident laundry was assigned. The LPN observed wheelchairs in rooms 151, 141, 139 and 132, which were two (2) rooms on each hallway. LPN #3 stated all the wheelchairs contained a build up of dust and particles on the undercarriage. LPN #3 stated all of the wheelchairs observed had enough build up of dust and dirt to indicate the wheelchairs had not been washed in at least several weeks. LPN #3 stated the wheelchairs had not been cleaned on either hall. Interview with the Director Of Nursing (DON), on 10/02/14 at 12:48 PM, revealed the night shift was responsible for taking the wheelchairs to the basement for cleaning. The DON stated it would be a problem if the wheelchairs were not being cleaned on a weekly basis. The DON stated they had a machine in the basement for washing wheelchairs.	F 253	f. The Administrator and the Director of Nursing revised the orientation check lists for licensed nurses and nursing assistants to include the revised wheelchair cleaning policy, flow sheet documentation, nurse leader audits 10/24/14. See attachments: F253 #7 Licensed Nurse Orientation Check List F253 #8 Certified Nursing Assistant Orientation Check List 4. The facility has initiated the following plans to monitor performance to ensure that the solutions are sustained as follows: a. The Director of Nursing will monitor completion of flow sheet assignments audits conducted by the nurse leaders on a weekly basis by using audit tool N-57 b. The Director of Nursing and the Assistant Director of Nursing will conduct weekly rounds to monitor wheelchair cleanliness and will document the findings utilizing the QA N-57 Audit tool and submit reports to the QAPI Committee on a monthly basis. c. The QAPI Committee will review audits monthly for six months to monitor effectiveness of the compliance plan then, assess revisions to monitor compliance.	F253 10/28/14
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		



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

PRINTED: 10/15/2014
FORM APPROVED
OMB NO. 0938-0391

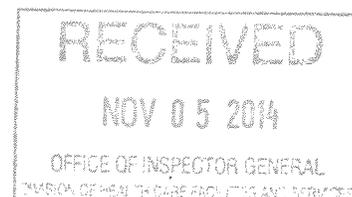
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/02/2014
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	Continued From page 5 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy, it was determined the facility failed to maintain four (4) of twenty (20) manual wheelchairs in one (1) of six (6) facility houses. The wheelchair arm coverings were observed with cracked vinyl arms and foam exposed for Residents #9, #11, unsampled Residents B and C. The findings include: Review of the Terminal Cleaning and Wheelchair Reassignment policy, revised December 2010, revealed equipment would be maintained in good working condition at all times and would be completed prior to returning any equipment into active service. The repair request would be communicated to the Maintenance Department via the Track It System (a request for repair or work order). Observation of a wheelchair, on 09/30/14 at 5:20 PM, revealed Resident #9's left wheelchair arm pad was cracked with rough edges. Observation of a wheelchair, on 09/30/14 at 5:15 PM, revealed Resident #11's left wheelchair arm	F 323	1. The affected Residents identified as Resident #9, Resident #11, un-sampled Resident B and Resident C, wheelchair arm rests, were addressed as follows: a. The Maintenance Director replaced the arm rests on the identified resident wheelchairs on 10/2/14. 2. To identify other resident wheelchair arm rests potentially affected by the issue the facility addressed as follows: a. The nurse leaders under the direction of the Director of Nursing conducted a 100% audit of all wheelchair arm rests on 10/2/14. The Maintenance Director was informed via the facility TRACK-IT system and repairs identified were completed by 10/2/14. See Attachment F323 #1 Audit report. 3. The Facility has initiated the following corrective measures to ensure that the deficient practice will not reoccur as follows: a. The Administrator and Director of Nursing developed a facility policy titled "Wheelchair Cleaning and Maintenance" on 10/17/14. See Attachment F 323 #2 Wheelchair Cleaning and Maintenance Policy b. The Director of Nursing revised the Nursing assistants' assignment sheet titled "Shower, Nail care, Laundry Flow Sheet" to include the schedule for wheelchair cleaning and Repairs on 10/17/14 See Attachment F 323#3 Shower, Nail care, Laundry, Wheelchair Cleaning and Repairs Flow sheet.		



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

PRINTED: 10/15/2014
FORM APPROVED
OMB NO. 0938-0391

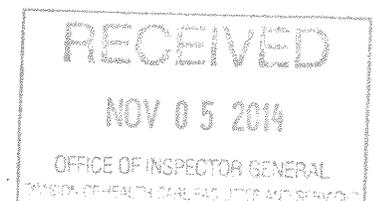
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/02/2014
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	Continued From page 6 pad was cracked with some of the vinyl missing. Observation of a wheelchair, on 09/30/14 at 5:20 PM, revealed Unsampled Resident B's left wheelchair arm pad was cracked with rough edges. Observation of a wheelchair, on 09/30/14 at 5:20 PM, revealed Unsampled Resident C's right wheelchair arm pad was cracked with blue foam exposed. Interview with the Owen House Leader, Licensed Practical Nurse #1, on 10/02/14 at 1:55 PM, revealed the Certified Nursing Assistants/Caregivers (CNA's) are assigned on third (3rd) shift to take residents' manual wheelchairs for washing and at that time inspect them for any need of repairs. The CNA's are then to report the need for repairs to the nurse, then the nurse or the House Leader would enter the needed repairs into the Track It System, (a request for repair or work order), for the Maintenance Department to repair the equipment. The House Leader stated she performed no audits to check the residents' equipment before today nor had she kept any logs as to when the residents' wheelchairs were last cleaned. The House Leader also stated the wheelchair's vinyl arm pads were cracked and had foam exposed and should have been identified and repaired before now. Interview with the Director of Nursing (DON), on 10/02/14 at 12:50 PM, revealed the potential problem with wheelchair arms that have cracked vinyl would be potential for skin tears for residents and this population had a potential for more fragile skin and possibly an infection with	F 323	c. The Director of Nursing developed an audit tool to be documented by the nurse leaders for the purpose of tracking audit (QA N-57) flow sheet completion and wheelchair cleanliness and repair reporting completed 10/17/14. See Attachment F 323 #4 N-57 Audit Tool d. The Director of Nursing conducted in-service to nurse leaders, staff nurses and nursing assistants on the revised policy, revised flow sheet, Track-It reporting system, and nursing compliance auditing process completed 10/27/14. See Attachment F323 # 5 – Nursing In-service form 10/27/14 e. The Administrator and the Maintenance Director developed an audit tool to track routine wheelchair repair checks to be performed by maintenance on a monthly basis on 10/17/14. See Attachment F323 #6 MNT-26 f. The Administrator in-serviced the Environmental Services Director and the Maintenance Director on the revised policy "Wheelchair Cleaning and Maintenance" on 10/22/14. See Attachment F 323# 7 In-service form 10/22/14 g. The Administrator and Director of Nursing revised the licensed nurse and nursing assistant orientation check lists to include the revised policy, revised flow sheet documentation and nurse leader audit process completed 10/24/14. See Attachments: F 323 # 8 Nurse Orientation F 323 #9 Nursing Assistant Orientation		



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

PRINTED: 10/15/2014
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 10/02/2014
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 323	Continued From page 7 opened areas on the skin. Interview with Director of Maintenance, on 10/02/14 at 2:45 PM, revealed the Maintenance Department relied on the nursing staff to inform them through the Track It System, when the residents had wheelchairs in need of repair. He further stated the Maintenance Department kept in stock extra sets of wheelchair arms for quick repair when needed. Interview with the DON, on 10/02/14 at 2:25 PM, revealed the facility provided training to the CNA's/Caregivers on 06/11/14 and 06/12/14 on cleaning and care of resident walkers and wheelchairs. Review of the training records revealed, the education provided to the CNA's/Caregivers on 06/11/14 and 06/12/14 on cleaning and care of resident walkers and wheelchairs did not include the identification or the reporting of resident equipment in need of repair.	F 323	4. The facility has initiated the following plans to monitor performance to ensure that the solutions are sustained as follows: a. The Director of Nursing will monitor completion of flow sheet assignment audits (QA N-57) by nurse leader on a weekly basis. b. The Director of Nursing and the Assistant Director of Nursing will conduct weekly rounds to monitor wheelchair cleanliness and repair needs and will document the findings utilizing the (QA N-57) audit tool; and submit to the QAPI Committee on a monthly basis. c. The Maintenance Director will conduct monthly rounds to monitor wheelchair conditions and repair needs and will document the findings on the MNT-26 audit tool and will submit findings to the QAPI Committee monthly d. The QAPI Committee will review the audits monthly for 6 months to monitor the effectiveness of the compliance plan and then recommend revisions to the monitoring schedules to maintain compliance.	F 323 10/28/14	



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

PRINTED: 10/03/2014
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 02 - SAM SWOPE CARE CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2014
--	--	---	--

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: SNF/NF DP</p> <p>TYPE OF STRUCTURES: Two (2) stories, Type II (222) protected construction.</p> <p>SMOKE COMPARTMENTS: Sixteen (16) smoke compartments; eight (8) on the First Floor and eight (8) on the Second Floor.</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 500 KW generator, fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 09/30/14. The facility was found not in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et. seq. (Life Safety from Fire).</p>	K 000		
-------	--	-------	--	--

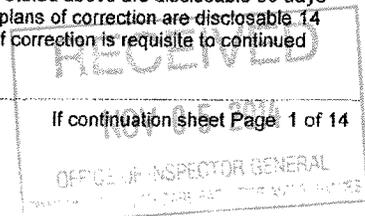
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

X *Leanne D. Stone*

TITLE _____ (X6) DATE

X *Executive Dir. Administrator* 11/5/14

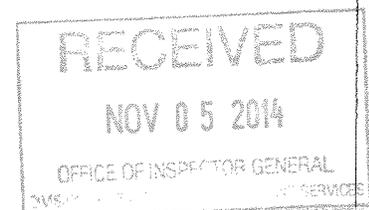
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

PRINTED: 10/03/2014
FORM APPROVED
OMB NO. 0938-0391

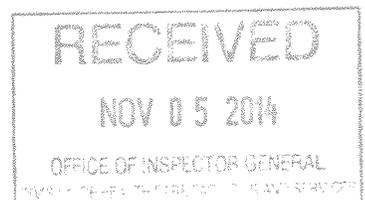
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SAM SWOPE CARE CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2014
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE			STREET ADDRESS, CITY, 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	Continued From page 1	K 000		
K 043 SS=E	<p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Patient room doors are arranged so that patients can open the door from inside without using a key. (Special door locking arrangements are permitted in mental health facilities.) 18.2.2.2.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide the protective features required for special locking arrangements for emergency exits in accordance with National Fire Protection (NFPA) standards. The deficiency had the potential to affect two (2) of sixteen (16) smoke compartments, approximately twenty-five (25) residents, staff and visitors. The facility has one-hundred and sixty-seven (167) certified beds and the census was one-hundred and thirteen (113) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 09/30/14 at 9:22 AM, with the Maintenance Director revealed the door exiting the second floor from Stairwell C, located in the Owen House, was equipped with fifteen (15) second delayed egress hardware, but there was no readily visible sign displayed advising that the door was on delayed egress. The sign should read, PUSH UNTIL ALARM SOUNDS, DOOR</p>	K 043	<p>1.The Maintenance Director removed the delayed egress feature from the second door in the egress path which was the exterior door in stairwell C on 9/30/14. He also removed the signage from this same door since it was no longer on delayed egress on 9/30/14.</p> <p>2.100% audit of all egress doors was completed on 9/30/14 by Maintenance Director and no other delayed egress concerns were found.</p> <p>3.The Maintenance Director installed readily visible signage on the door exiting the second floor from Owen Household into stairwell C. He also installed readily visible signage on the door exiting the first floor from Judy House into stairwell C. Both signs read "Push until Alarm Sounds. Door can be opened in 15 seconds". Administrator educated Maintenance Director on 9/30/14 of the requirement that delayed egress locks are permitted provided that not more than one such device is located in any egress path. See attachment K043 #1</p> <p>Maintenance revised the indicator Mnt-15 to include checking egress signage and checking only one delayed egress on path of egress on 10/17/14. See attachment K043 #2</p>	



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

PRINTED: 10/03/2014
FORM APPROVED
OMB NO. 0938-0391

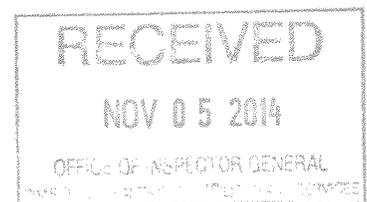
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SAM SWOPE CARE CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 09/30/2014
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE			STREET ADDRESS, 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 043	<p>Continued From page 2 CAN BE OPENED IN 15 SECONDS.</p> <p>Interview, on 09/30/14 at 9:24 AM, with the Maintenance Director revealed the facility installed the delayed egress hardware on the door to Stairwell C approximately one (1) month ago for the clinical needs of the residents residing in the Owen House. He was not aware of the required sign not being installed yet.</p> <p>Observation, on 09/30/14 at 9:30 AM, with the Maintenance Director revealed the exit access door from Stairwell C to the exterior of the building was equipped with fifteen (15) second delayed egress hardware with the proper signage displayed. While exiting the building in the event of an emergency, delayed egress locks are permitted provided that not more than one such device is located in any egress path. Doors entering Stairwell C from the first and second floor corridors were equipped with delayed egress hardware.</p> <p>Interview, on 09/30/14 at 9:32 AM, with the Maintenance Director revealed he was not aware of the requirement that delayed egress locks are permitted provided that not more than one such device was located in any egress path.</p> <p>Observation, on 09/30/14 at 9:39 AM, with the Maintenance Director revealed the door exiting the first floor from Stairwell C, located in the Judy House, was equipped with fifteen (15) second delayed egress hardware, but there was no readily visible sign displayed advising that the door was on delayed egress. The sign should read, PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 15 SECONDS.</p>	K 043	<p>4.a. Maintenance will complete the monthly audit on indicator Mnt- 15 Exits, Stairways, and Fire Escapes and submit findings to QAPI committee monthly.</p> <p>b. The QAPI Committee will review the findings for 3 months and then evaluate revision of audit schedule as appropriate to sustain compliance.</p>	K 043 10/28/14	



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

PRINTED: 10/03/2014
FORM APPROVED
OMB NO. 0938-0391

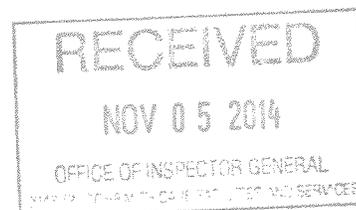
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SAM SWOPE CARE CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 09/30/2014
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE			STREET ADDRESS, 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 043	<p>Continued From page 3</p> <p>Interview, on 09/30/14 at 9:41 AM, with the Maintenance Director revealed the facility installed the delayed egress hardware on the door to Stairwell C approximately one (1) month, ago for the clinical needs of the residents residing in the Judy House. He was not aware of the required sign not being installed yet.</p> <p>The census of one-hundred and thirteen (113) was verified by the Administrator on 09/30/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 09/30/14</p> <p>Reference NFPA 101 (2000 Edition)</p> <p>7.2.1.6 Special Locking Arrangements.</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power</p>	K 043			



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

PRINTED: 10/03/2014
FORM APPROVED
OMB NO. 0938-0391

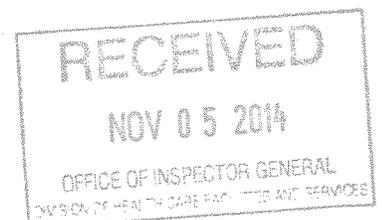
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SAM SWOPE CARE CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2014
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE			STREET ADDRESS, CITY, 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 043	<p>Continued From page 4</p> <p>controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>7.2.1.6.2 Access-Controlled Egress Doors. Where permitted in Chapters 11 through 42, doors in the means of egress shall be permitted to be equipped with an approved entrance and egress access control system, provided that the following criteria are met.</p> <p>(a) A sensor shall be provided on the egress side and arranged to detect an occupant approaching the doors, and the doors shall be arranged to unlock in the direction of egress upon detection of an approaching occupant or loss of power to the sensor.</p> <p>(b) Loss of power to the part of the access control system that locks the doors shall automatically unlock the doors in the direction of egress.</p> <p>(c) The doors shall be arranged to unlock in the</p>	K 043		



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

PRINTED: 10/03/2014
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 02 - SAM SWOPE CARE CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 09/30/2014
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 043	Continued From page 5 direction of egress from a manual release device located 40 in. to 48 in. (102 cm to 122 cm) vertically above the floor and within 5 ft (1.5 m) of the secured doors. The manual release device shall be readily accessible and clearly identified by a sign that reads as follows: PUSH TO EXIT When operated, the manual release device shall result in direct interruption of power to the lock - independent of the access control system electronics - and the doors shall remain unlocked for not less than 30 seconds. (d) Activation of the building fire-protective signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. (e) Activation of the building automatic sprinkler or fire detection system, if provided, shall automatically unlock the doors in the direction of egress and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. 18.2.2.2 Doors. 18.2.2.2.1 Doors complying with 7.2.1 shall be permitted. 18.2.2.2.2 Locks shall not be permitted on patient sleeping room doors. Exception No. 1: Key-locking devices that restrict access to the room from the corridor and that are operable only by staff from the corridor side shall be permitted. Such devices shall not restrict egress from the room. Exception No. 2: Door-locking arrangements	K 043			



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

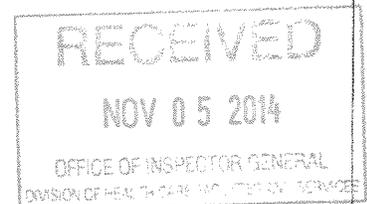
PRINTED: 10/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SAM SWOPE CARE CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2014
--	--	---	--

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
--------------------	--	---------------	---	----------------------

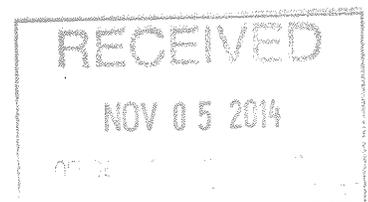
K 043	Continued From page 6 shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that keys are carried by staff at all times. 18.2.2.2.3 Doors not located in a required means of egress shall be permitted to be subject to locking. 18.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 18.1.1.1.5 and 18.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. 18.2.2.2.5 Doors located in the means of egress that are permitted to be locked under other provisions of this chapter shall have adequate provisions made for the rapid removal of occupants by means such as remote control of locks, keying of all locks to keys carried by staff at all times, or other such reliable means available to the staff at all times. Only one such locking device shall be permitted on each door. Exception: Locks in accordance with Exception Nos. 2 and 3 to 18.2.2.2.4	K 043		
-------	--	-------	--	--



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

PRINTED: 10/03/2014
FORM APPROVED
OMB NO. 0938-0391

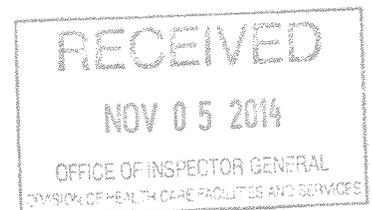
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SAM SWOPE CARE CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2014
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE			STREET ADDRESS, CITY, 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 045 K 045 SS=F	Continued From page 7 NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 18.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the sixteen (16) smoke compartments, residents, staff and visitors. The facility has one-hundred and sixty-seven (167) certified beds and the census was one-hundred and thirteen (113) on the day of the survey. The findings include: Observation, on 09/30/14 at 9:32 AM, with the Maintenance Director revealed the exit from Stairwell C, to the exterior of the building did not have a light installed outside to provide the required illumination for exit discharge. The exit was equipped with a light fixture tied into the emergency power; however, the light fixture only had one (1) bulb. Egress lighting was required to be arranged so that failure on any single lighting fixture (bulb) would not leave the area in darkness. Interview, on 09/30/14 at 9:34 AM, with the Maintenance Director revealed he was not aware	K 045 K 045	1. There were no individual residents identified to have been affected by the deficient practice. 2. The 113 residents potentially affected by the same deficient practice were addressed as specified under #3 & #4. 3a. Maintenance Director contacted Henderson Electric on 10/01/14 to evaluate existing exit lighting for compliance with National Fire Protection Association (NFPA) standards. It was determined that the fixtures could be replaced with two bulb fixtures. b. 100% Audit was completed on exterior lighting on all egress and exits on 10/1/14 with Henderson Electric. They determined 12 replacement fixtures were needed and the light for the one exit missing a fixture. Henderson Electric replaced the one missing fixture on 10/22/14. c. The Administrator and Maintenance Director reviewed and revised indicator Mnt- 24 to include "all egress lighting has two functioning bulbs in the fixtures". See attachment K045 #1 d. Lighting fixtures that meet National Fire Protection Association (NFPA) standards were installed by Henderson Electric by 10/24/14. See attachment K045 #2	



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

PRINTED: 10/03/2014
FORM APPROVED
OMB NO. 0938-0391

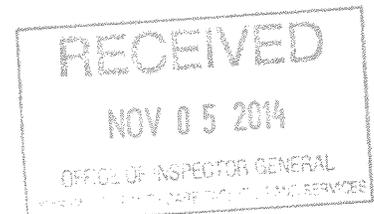
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SAM SWOPE CARE CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2014
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE			STREET ADDRESS, CITY, 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 045	<p>Continued From page 8</p> <p>the exit from Stairwell C did not have the required illumination for egress lighting.</p> <p>Observation, on 09/30/14 at 9:53 AM, with the Maintenance Director revealed the exit from Stairwell B, to the exterior of the building did not have any egress light fixtures installed outside to provide the required illumination for exit discharge. Egress lighting is required to be arranged so that failure of any single lighting fixture (bulb) would not leave the area in darkness.</p> <p>Interview, on 09/30/14 at 9:55 AM, with the Maintenance Director revealed he was not aware the exit from Stairwell B did not have the required illumination for egress lighting.</p> <p>Observation, on 09/30/14 at 10:04 AM, with the Maintenance Director revealed the exit from Stairwell E, to the exterior of the building did not have a light installed outside to provide the required illumination for exit discharge. The exit was equipped with a light fixture tied into the emergency power; however, the light fixture only had one (1) bulb. Egress lighting was required to be arranged so that failure of any single lighting fixture (bulb) would not leave the area in darkness.</p> <p>Interview, on 09/30/14 at 10:06 AM, with the Maintenance Director revealed he was not aware the exit from Stairwell E, did not have the required illumination for egress lighting.</p> <p>Observation, on 09/30/14 at 10:11 AM, with the Maintenance Director revealed the exit from Stairwell F, to the exterior of the building did not have a light installed outside to provide the</p>	K 045	<p>4.a.Maintenance will complete the monthly audit MNT-24 and submit findings to the QAPI committee monthly.</p> <p>b. The QAPI Committee will review the findings for 3 months and then evaluate revision of audit schedule as appropriate to sustain compliance.</p>	F 045 10/28/14



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

PRINTED: 10/03/2014
FORM APPROVED
OMB NO. 0938-0391

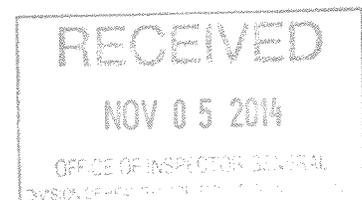
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SAM SWOPE CARE CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2014	
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE		STREET ADDRESS, CITY, 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 045	<p>Continued From page 9</p> <p>required illumination for exit discharge. The exit was equipped with a light fixture tied into the emergency power; however, the light fixture only had one (1) bulb. Egress lighting is required to be arranged so that failure of any single lighting fixture (bulb) would not leave the area in darkness.</p> <p>Interview, on 09/30/14 at 10:13 AM, with the Maintenance Director revealed he was not aware the exit from Stairwell F did not have the required illumination for egress lighting.</p> <p>Observation, on 09/30/14 at 10:22 AM, with the Maintenance Director revealed the exit from Stairwell G, to the exterior of the building did not have a light installed outside to provide the required illumination for exit discharge. The exit was equipped with a light fixture tied into the emergency power; however, the light fixture only had one (1) bulb. Egress lighting was required to be arranged so that failure of any single lighting fixture (bulb) would not leave the area in darkness.</p> <p>Interview, on 09/30/14 at 10:24 AM, with the Maintenance Director revealed he was not aware the exit from Stairwell G, did not have the required illumination for egress lighting.</p> <p>Observation, on 09/30/14 at 10:27 AM, with the Maintenance Director revealed the exit from Stairwell H, to the exterior of the building did not have a light installed outside to provide the required illumination for exit discharge. The exit was equipped with a light fixture tied into the emergency power; however, the light fixture only had one (1) bulb. Egress lighting was required to be arranged so that failure of any single lighting</p>	K 045		



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

PRINTED: 10/03/2014
FORM APPROVED
OMB NO. 0938-0391

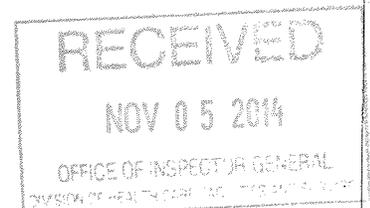
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SAM SWOPE CARE CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2014
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE		STREET ADDRESS, CITY, 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)
K 045	<p>Continued From page 10 fixture (bulb) would not leave the area in darkness.</p> <p>Interview, on 09/30/14 at 10:29 AM, with the Maintenance Director revealed he was not aware the exit from Stairwell H did not have the required illumination for egress lighting.</p> <p>The census of one-hundred and thirteen (113) was verified by the Administrator, on 09/30/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 09/30/14.</p> <p>Reference NFPA 101 (2000 edition)</p> <p>18.2.7 Discharge from Exits.</p> <p>Discharge from exits shall be arranged in accordance with Section 7.7.</p> <p>18.2.8 Illumination of Means of Egress.</p> <p>Means of egress shall be illuminated in accordance with Section 7.8.</p> <p>7.7 DISCHARGE FROM EXITS 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6.</p>	K 045	



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

PRINTED: 10/03/2014
FORM APPROVED
OMB NO. 0938-0391

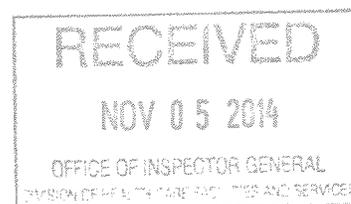
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SAM SWOPE CARE CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2014
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE			STREET ADDRESS, CITY, 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 045	Continued From page 11 Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23. 7.7.2 Not more than 50 percent of the required number of exits, and not more than 50 percent of the required egress capacity, shall be permitted to discharge through areas on the level of exit discharge, provided that the criteria of 7.7.2(1) through (3) discharge as provided in Chapters 22 and 23. Exception No. 3: In existing buildings, the 50 percent limit on egress capacity shall not apply if the 50 percent limit on the required number of exits is met. 7.7.3 The exit discharge shall be arranged and marked to make clear the direction of egress to a public way. Stairs shall be arranged so as to make clear the direction of egress to a public way. Stairs that continue more than one-half story beyond the level of exit discharge shall be interrupted at the level of exit discharge by partitions, doors, or other effective means. 7.7.4 Doors, stairs, ramps, corridors, exit passageways, bridges, balconies, escalators, moving walks, and other components of an exit discharge shall comply with the detailed requirements of this chapter for such components. 7.7.5 Signs. (See 7.2.2.5.4 and 7.2.2.5.5.) 7.7.6 Where approved by the authority having jurisdiction, exits shall be permitted to discharge to roofs or other sections of the building or an adjoining building where the following criteria are met:	K 045		



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

PRINTED: 10/03/2014
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 02 - SAM SWOPE CARE CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2014
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 045	Continued From page 12 (1) The roof construction has a fire resistance rating not less than that required for the exit enclosure. (2) There is a continuous and safe means of egress from the roof. 7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and	K 045		



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

PRINTED: 10/03/2014
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 02 - SAM SWOPE CARE CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 09/30/2014
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 045	Continued From page 13 exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045			

