

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

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PRINTED: 05/24/2012
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 C 05/11/2012
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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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F 000	INITIAL COMMENTS An abbreviated survey was initiated on 05/09/12 and concluded on 05/11/12 investigating KY18204 and KY18316. The Division of Health Care unsubstantiated KY18204 with no deficiencies cited and substantiated KY18316 with a deficiency 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 223 SS=G	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's Abuse and Neglect Policy and Procedure, Incident Form, and the facility's investigation, it was determined the facility failed to protect one (1) of five (5) sampled residents, Resident #2, from verbal, physical and emotional abuse. On 05/04/11 Certified Nursing Assistant (CNA) #4 told Resident #2 that he/she did not have to use the bathroom, after the resident had just requested to be taken to the bathroom. CNA #4 was heard to say she did not "have time for this" and that Resident #2 was going to give her a nervous breakdown. CNA #4 was also heard to tell Resident #2 that what he/she did need was to get back in bed. CNA #4 then grabbed the resident out of his/her wheelchair forcefully and	F 223	F 223 1) Upon awareness of incident the caregiver had no further contact with any other residents. Per findings from investigation by Nurse Leader CNA #4 was terminated. Resident #2 was assessed for injury. No follow up treatment needed. 2) Nurse Leader and Household Coordinator surveyed residents in adjacent hallway and no other concerns expressed. Residents in our Community will be surveyed by administrative staff by June 5 th . Any concern will be promptly addressed and reported to Quality Assurance committee by Executive Director. 3) All staff (Activities, Administration, Central Supply, Environmental Services, Food Service, Nursing-CMT, Caregivers, household nurses, Nursing Administration, Health Information) employed for the Masonic Home of Louisville were re educated on abuse policy and community requirements for reporting by the Director of Nursing and Executive Director by June 5, 2012. Medical Director along	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>x Henri A Hess</i>	TITLE <i>x Ex Director</i>	(X6) DATE <i>x 6/13/12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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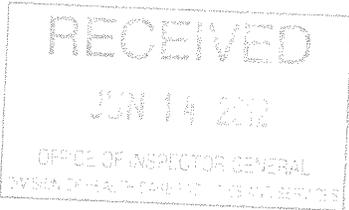
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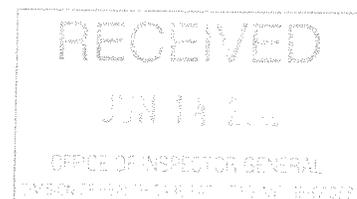
F 223	<p>Continued From page 1</p> <p>tossed the resident onto the bed, hitting his/her right leg against the bed rail. The resident responded with an "ow". CNA #4 then got about six (6) inches from the face of Resident #2 and stated "I didn't hurt you, did I? I haven't been mean to you, have I?" Resident #2 expressed pain, and redness was exhibited on his/her right leg from being hit against the side rail during the transfer. The facility's failure to ensure the rights of the residents to be free from abuse resulted in actual harm to Resident #2.</p> <p>The findings include:</p> <p>Review of the facility's Abuse and Neglect Policy and Procedure, revised October 2011, revealed verbal abuse was oral or gestured language that included disparaging or derogatory terms to the resident. Physical abuse included hitting, slapping, pinching, scratching, spitting, holding a resident roughly, etc. It also included controlling behavior through corporal punishment. Emotional abuse was defined as, but was not limited to, humiliation, harassment, and threats of punishment or deprivation. Additionally, the facility was to ensure prevention techniques were implemented in the center such as, identify, correct and intervene in situations where abuse and/or neglect was more likely to occur.</p> <p>Review of the facility's investigation revealed an incident, dated 05/04/12, in which a caregiver, CNA #4, was overheard and then observed by Registered Nurse (RN) #1 to verbally and physically abuse Resident #2. A statement from RN #1 revealed she had overheard CNA #4 tell Resident #2 that he/she did not have to use the bathroom, after the resident had just requested to</p>	F 223	<p>with the Executive Director reviewed facilities Abuse and Neglect Policy and Procedure on May 30, 2012 with no additions or changes needed to policy and procedure. Medical Director and Executive Director reviewed statement of deficiencies and discussed plan of correction on May 30, 2012. RN #1 was re educated on the community's Abuse and Neglect Policy on May 4, 2012.</p> <p>4) Household coordinators, healthcare administration intern, office manager and social services assistant will interview three residents on each of our six households every week for four weeks and report interview findings to Executive Director. Thereafter, household coordinators, healthcare administration intern, office manager and social services assistant will interview three residents on each house for two months and report findings to Executive Director. Results of interviews will be immediately addressed and findings presented by Executive Director to Quality Assurance committee and Medical Director monthly for further recommendations for three months and continue until the Quality Assurance team and Medical Director determines discontinuance is acceptable.</p> <p>5) Compliance Date: June 6, 2012</p>	
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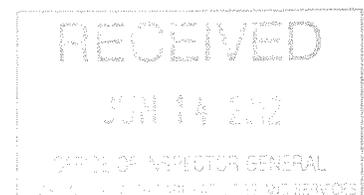
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F 223	<p>Continued From page 2</p> <p>be taken to the bathroom. CNA #4 was heard to say she did not "have time for this" and that Resident #2 was going to give her a nervous breakdown. CNA #4 was also heard to tell Resident #2 that what he/she did need was to get back in bed. RN #1 then entered the room of Resident #2 and observed CNA #4 grab the resident out of his/her wheelchair forcefully and toss the resident onto the bed, hitting his/her right leg against the bed rail. The resident responded with an "ow". RN #1 then told CNA #4 that it was not appropriate to talk to or treat a resident in that manner. RN #1 revealed CNA #4 then got about six (6) inches from the face of Resident #2 and stated "I didn't hurt you, did I? I haven't been mean to you, have I?" Resident #2 revealed he/she did not want CNA #4 to come back to take him/her to the bathroom because CNA #4 was impatient and mean to him/her. A skin assessment by RN #1 of Resident #2's right leg, revealed redness to the area which came in contact with the bed rail. In addition, a statement by the Director of Nursing, dated 05/04/12, revealed CNA #4 was terminated for verbal abuse and rough handling.</p> <p>Interview, on 05/11/12 at 10:00 AM, with RN #1 revealed there was discoloration to the outside of the right leg of Resident #2 where he/she had hit his/her leg when being tossed onto the bed by CNA #4. RN #1 stated Resident #2 was "definitely fearful of the CNA," referring to CNA #4. The incident occurred at the change of shift and the CNA clocked out and left the building. The incident was reported to administration and an investigation was initiated.</p> <p>Interview, on 05/10/11 at 6:30 AM, with the RN,</p>	F 223		



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F 223	<p>Continued From page 3</p> <p>Nurse Leader of the Walters House, revealed the incident had occurred at the change of shift around 6:30 AM. She revealed while making her rounds, RN #1 told her CNA #4 had physically and verbally abused a resident. She further revealed there was a reddened area to the leg of Resident #2 immediately after the incident.</p> <p>Review of the clinical record for Resident #2 revealed the facility admitted the resident on 04/20/12 with diagnoses of After Care Traumatic Fracture Bone, After Care Internal Fixation Device, Senile Dementia, Difficulty Walking and Muscle Weakness. The resident had fractured his/her left knee cap, had surgery, and was in the facility for rehabilitation. The facility assessed the resident as cognitively impaired.</p> <p>Observation of Resident #2, on 05/10/12 at 9:40 AM, revealed the resident in the room, laying in bed sleeping, in an upright position at 45 degrees. The resident's call light cord was attached to the lanyard around his/her neck. Continued observation, on 05/11/12 at 11:05 AM, revealed the resident up in a wheelchair with a splint in place to the left leg. During the observation the resident stated his/her left knee (fractured prior to admission) was hurting; however, could not state the day, the date or the history of the injury to the left knee. There were no visible bruises or additional injuries noted.</p> <p>Interview, on 05/11/12 at 8:15 AM, with the daughter of Resident #2 revealed the resident had been calling her everyday for the past two (2) weeks at about 8:30 AM crying and saying he/she needed to go to the bathroom. The daughter said she had asked the resident if the call light was</p>	F 223		



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F 223	Continued From page 4 being used and the resident revealed there was an employee who was mean to him/her. The daughter revealed she was told the employee would tell the resident "I can't help you right now," and then walk out of the room. The daughter stated she did not report this to anyone because the resident had a diagnosis of dementia. The daughter stated Resident #2 had not reported being hit or pulled on. Attempted interview via telephone with CNA #4, on 05/10/12 at 8:50 AM, was unsuccessful.	F 223		

