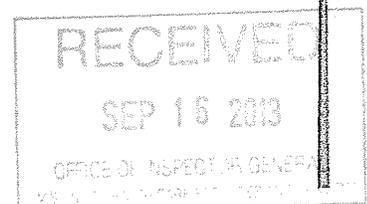


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

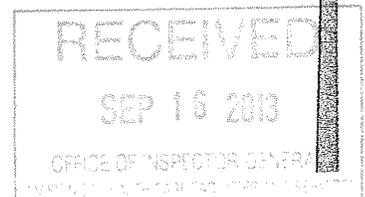
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185388</b>  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                              |   | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2013</b> |
|---|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MASONIC HOME OF LOUISVILLE</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>240 MASONIC HOME DRIVE<br/>MASONIC HOME, KY 40041</b> |   |   |
| (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 428   | <p>Continued From page 39</p> <p>the readmission physician order sheet (POS), dated 07/02/13, revealed Resident #31 had Lasix (a drug used to remove extra fluid) 40 milligrams by mouth daily ordered. Further review of Resident #31's physician orders revealed a telephone order dated 07/12/13 to increase Lasix to 40 milligrams daily and to add Lasix 20 milligrams by mouth daily for three (3) days.</p> <p>Review of the Electronic Medication Administration Record (EMAR) revealed the Lasix 40 milligram order was on the EMAR twice (a duplicated order) and the duplicated Lasix 40 milligrams was documented as having been given twice on 07/13/13, 07/14/13, once on the 07/15/13 and twice on 07/16/13. Review of the pharmacy monthly regimen review, dated July 2013, revealed no recommendations for physician clarification pertaining to the Lasix 40 mg. Review of the notes attached to the EMAR revealed The Certified Medication Technician (CMT) administered the routine 40 mg dose of Lasix and held the duplicated dose on 07/15/13 as the CMT assigned to administer those medications had recognized the duplicated order.</p> <p>On 07/26/13 at 1:40 PM, interview with CP #7 revealed the facility policies and contract for pharmacy services and the CPs were from the nursing home in the old building, and had not been revised since the facility moved to the new building. She stated if nurses enter information into the electronic chart and EMAR, no one from pharmacy would be aware if information was keyed incorrectly, or entered for the wrong resident. The CP stated she did not have access to the facility's electronic chart and EMAR. She stated it was important for the CP to review the EMARs to ensure resident's medications were</p> | F 428   |   |   |



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

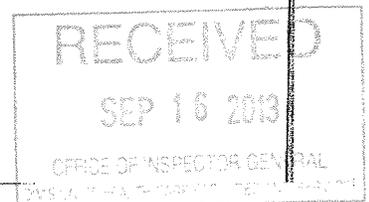
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
|--|--|--|---|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 428  | <p>Continued From page 40</p> <p>received and documented. The CP stated the facility could print the EMARs for the CP to review during the Medication Regimen Review. Interview, on 07/26/13 at 2:52 PM, with the Director of Nursing (DON) revealed she was unaware if pharmacy had access to the facility's electronic chart and EMAR. She stated the CP could review the EMAR if requested.</p> <p>3. Review of the clinical record for Resident #35 revealed the facility admitted the resident on 06/24/13, to the Dementia Unit with diagnoses of Dementia with Behaviors, Osteoarthritis, Anxiety, Gastric Reflux, Coronary Artery Disease, and Degenerative Joint Disease. Review of the resident's admission orders, dated 06/24/13, revealed an order for Vitamin B-12 1000 mcg orally to be given every day. However, review of the Electronic Medication Administration Record (EMAR) revealed the facility entered the order and the resident received Vitamin B-12 at 250 mcg orally every day. Continued review of the resident's record revealed pharmacy completed a Medication Regimen Review, dated 07/25/13, but did not address that there was a medication discrepancy between the orders and the EMAR. A clarification order was written by the Assistant Director of Nursing (ADON), on 07/29/13, for the Vitamin B-12 at 1000 mcg which was thirty-four (34) days after the discrepancy occurred.</p> <p>Interview with Licensed Practical Nurse (LPN) #12, on 08/01/13 at 3:40 PM, revealed she did input admission orders into the EMAR computer system. However, the LPN revealed she was not aware the transcription error occurred.</p> <p>Interview with Consulting Pharmacist #10, on 08/01/13 at 4:22 PM, revealed comparing orders</p> | F 428  |   |                      |  |



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

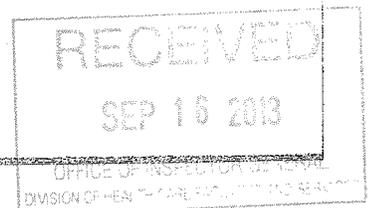
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
|--|---|--|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 428  | Continued From page 41<br>against the actual EMAR was not part of their contract. The pharmacist revealed they do a regimen review and not a medical record review. Continued interview, on 08/01/13 at 4:50 PM, revealed he was not sure what the policy and procedure, or contract stated regarding resident reviews. The pharmacist stated he would have to read their policies again.   | F 428  |  |  |
| F 431<br>SS=E  | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>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.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>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.<br><br>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 | F 431  | 1. No resident was identified as being affected by the issues identified. However, the facility has implemented corrective actions to address the deficient practice as stated under items 3 and 4.<br><br>2. No other residents were identified as being affected by the issues identified. However the facility has implemented corrective actions to address the issues identified as stated under items 3 and 4.<br><br>3. The facility has initiated the following corrective actions to assure that identified issue does not reoccur as follows:<br>• Director of Nursing and Pharmacy Consultants directed transition of medication storage from the individual resident's room to a medication cart located in the nursing station medication room on 8-8-2013 for the three households affected.<br>• CP conducted education to pharmacy staff who consult or review medication storage including: medication carts, medication rooms and the audit protocol that will be used on 8-13-2013<br>• CP conducted review of applicable internal medication storage policies to verify current application to facility operations on 8-27-2013<br><br>4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows:<br>• Pharmacy will perform a monthly audit to assure medications are stored in compliance with regulation and submit to QA and Director of Nursing for review. |  |



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

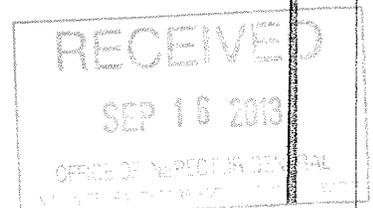
|  |  |  |   |  |
|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 431  | <p>Continued From page 42</p> <p>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:<br/>Based on interview, record review, and review of the facility's policy, it was determined the facility failed to maintain pharmacy services and procedures that ensured three (3) of six (6) resident houses with medications stored in medicine cabinets in the residents' rooms were properly maintained.</p> <p>The findings include:</p> <p>Review of the facility's policy Consultant Pharmacist Services Provider Requirements, not dated, revealed the Consultant Pharmacist (CP) would evaluate the process of storing all medications. The CP would check medication storage areas at least monthly.</p> <p>Review of the CP Agreement, dated 07/18/09, revealed the CP would work with facility staff to ensure inspections were done on medication storage areas and the findings were reported in the consultant report.</p> <p>Interview with CP #3, on 07/25/13 at 12:31 PM and on 07/26/13 at 10:43 AM and 1:50 PM, revealed the medication rooms at the nurses' stations were inspected monthly, in addition to the medication carts. However, some units did not have medication carts. The medications were stored in cabinets in the residents' rooms. He</p> | F 431  | <ul style="list-style-type: none"> <li>Administrator will be responsible for monitoring to ensure effectiveness of the compliance plan.</li> <li>The Pharmacy will audit drug storage areas every 2 weeks for six weeks and then monthly thereafter and submit to QA and Director of Nursing for review.</li> </ul> <p>The Quality Assurance Committee will review required audits and supportive documentation monthly to ensure the effectiveness of the compliance plan and make revisions as necessary on an ongoing basis.</p> <p>5. Completed by:</p> | 8-28-2013                                    |



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

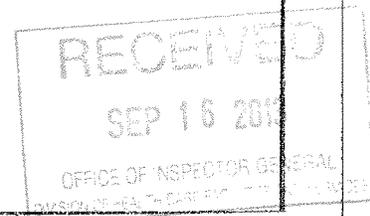
|  |  |  |   |  |
|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 431  | <p>Continued From page 43</p> <p>stated the CPs did not go into resident rooms to check medicine cabinets. The CP stated facility staff was responsible for checking the medicine cabinets in resident rooms. He stated he was unsure if the pharmacy supplied the facility with a checklist or audit tool, or who specifically in the Nursing Department was responsible for conducting the audit. The CP stated he was unaware of the facility's policy or the Pharmacy and CP Agreements for auditing the medicine cabinets in the resident rooms. He stated when the facility was in the other building it was a traditional nursing home and the CP would check the medicine carts. During further interview, he stated when the facility moved into the new building, the facility chose to store medications in resident rooms. The CP stated the pharmacy would continue to check medication carts and medications rooms; however, resident rooms were not considered medication carts or medication rooms.</p> <p>On 07/25/13 at 12:45 PM, interview with CP #2 revealed the CPs did not check medications that were stored in resident medicine cabinets. He stated Nursing was responsible to audit the resident medicine cabinets. The CP stated Nursing was also responsible to follow-up and ensure that the medicine cabinets were being audited by the person(s) responsible to conduct the audit.</p> <p>Interview, on 07/26/13 at 9:22 AM, with Licensed Practical Nurse (LPN) #7 revealed he had not seen a CP check medications in medicine cabinets. The LPN stated the nurses checked medications for expiration dates and he was unaware of who would have been responsible to remove medications from the medicine cabinets.</p> | F 431  |   |  |



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

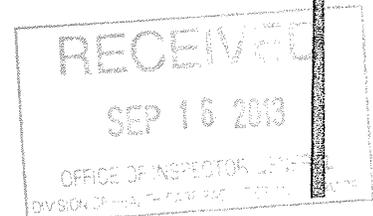
|   |   |   |  |   |
|---|---|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                      |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185388</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MASONIC HOME OF LOUISVILLE</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>240 MASONIC HOME DRIVE<br/>MASONIC HOME, KY 40041</b>  |   |
| (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 431   | Continued From page 44<br><br>Interview with the Director of Nursing (DON), on 07/26/13 at 9:48 AM, revealed three (3) long term care units in the facility had medications stored in resident rooms and the other three (3) units had transitioned back to medication carts. The DON stated Nursing was responsible for checking the medication cabinets in resident rooms.<br><br>On 07/26/13 at 1:50 PM, interview with CP #1 revealed she did not go into resident rooms to check the resident medicine cabinets. The CP stated the facility was responsible when the medications were moved and stored in resident rooms. She stated the resident MARs should state nursing was to check the medicine cabinets. The CP stated pharmacy would not be responsible for the medicine cabinets in resident rooms. | F 431   |  |   |
| F 490<br>SS=K   | 483.75 EFFECTIVE<br>ADMINISTRATION/RESIDENT WELL-BEING<br><br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and facility policy review it was determined the facility failed to be administered to maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility failed to  | F 490   | 1. Residents # 1, #3, #5, #6, #16, #29, #31, #35, and #H were identified as affected by the identified issue. The facility addressed the residents as follows:<br><br>Resident #1 was discharged from the facility to the hospital on 4-15-13 and did not return.<br>Resident #3 - a clarification order was obtained from the attending physician on 7-24-2013. Resident #3 had received the Lovenox per the physician order as indicated on the medication administration record. The facility disagrees that this is a breach of professional standard by the nurse involved.<br><i>Physician's order was signed on 8/5/2013</i><br>Resident #5 - on 6-11-13 the nurse practitioner ordered Allpurinol in response to a pharmacy recommendation. The order was discontinued on 7-9-13 by the nurse practitioner due to resident refusal of medication. The facility disagrees that this is a breach of professional standard by the nurse involved.<br>Resident #6 - the nursing staff conducted the resident's tuberculin testing on 7-24-2013 which was found to be negative on 7/26/2013, tuberculin testing |   |



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

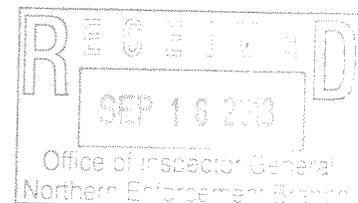
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                      |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185388</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                      | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2013</b> |
|---|---|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MASONIC HOME OF LOUISVILLE</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>240 MASONIC HOME DRIVE<br/>MASONIC HOME, KY 40041</b>  |                      |   |
| (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 490   | Continued From page 45<br>have an effective system to ensure policy and procedures were implemented related to medication orders and failed to ensure licensed staff followed nursing standards of practice. On 03/22/13 the facility admitted Resident #1 with an order for Cefazolin (an antibiotic) two (2) grams to be administered daily intravenously (IV) for twenty-eight (28) days for a hip and elbow infection. However, the facility staff failed to transcribe the order to the Medication Administration Record to ensure medication administration occurred. In addition, the admitting Licensed Practical Nurse (LPN) #3 altered the physician's order by adding to the directions to administer the antibiotic "after HD on HD", (after hemodialysis on hemodialysis days). This order was never verified with the resident's physician and the dialysis center was not aware of the antibiotic therapy. Record review revealed no documented evidence Resident #1 received the antibiotic on 03/22/13 through 04/14/13 twenty-four (24) of the twenty-eight (28) days as ordered by the physician. On 04/15/13, the resident developed a mental status change and was transferred to the hospital and admitted with an impression of Toxic Metabolic Encephalopathy secondary to gram-positive cocci Septicemia with Bacteremia, likely a recurrence of underlying MSSA Sepsis. The resident did not return to the facility, but was transferred to another local Long Term Care facility and expired on 05/02/13.<br><br>Interview and record review revealed medication errors and/or transcription errors for eight (8) of thirty-eight (38) sampled residents (Residents #1, #3, #5, #6, #16, #29, #31, #35) and one (1) unsampled resident (Unsampled Resident H) during the standard/abbreviated survey. (Refer to F281, F333, F514 and F520) | F 490   | step two on 8/1/2013 found to be negative on 8/3/2013. The facility disagrees that this is a breach of professional standard by the nurse involved. Resident #16 - attending physician signed the order for Levaquin on 7/9/2013. Resident #16 did receive the medication under physician order after hospital discharge. The facility disagrees that this is breach of professional standard by the nurse involved. Resident #29 - an order for Lasix 20mg was obtained from the nurse practitioner on 7/15/2013 and signed by the attending physician on 7-18-13. The facility disagrees that this is a breach of professional standard by the nurse involved. Resident #31 - resident #31 40 mg Lasix order reviewed by physician on 7/26/2013. <i>EMAR corrected on 7/16/2013</i> Resident #35 - a clarification order was obtained on 7-29-2013 to correct the administration record. The facility disagrees that this is a breach of professional standard by the nurse involved. Resident #H - on 4-22-13 floor RN completed the transcription of the order for Melatonin. The facility disagrees that this is a breach of professional standard by the nurse involved. <i>Incident report made on 4/22/2013 and Physician notified 4/22/2013.</i><br>2. To identify other residents that might be affected, the Quality Assurance Consultants, under recommendation of the Quality Assurance Committee (DON, ADON, Administrator, ANC), completed a chart review beginning 7/1/13 through 7/31/13 that included review of current residents' physician orders and medication administration records.<br>• For 100% resident review, Nursing Reviews that included review of current residents' physician orders and medication administration records as documented from the original physician order source, were completed between 7/1/2013 and 7/25/2013 by Director of Nursing (DON), Assistant Director of Nursing (ADON), Administrative Nurse Consultants (ANC), and Nursing Consultants s on all existing residents' orders, new orders, and new admissions' orders.<br>• All transcription orders were reviewed by DON, ADON, and ANC on 7/25/2013 upon the recommendations of the Pharmacy medication regimen order review, 116 total resident reviews (100%), completed on 7/25/2013. |                      |   |



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
|--|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 490  | Continued From page 46<br><br>The facility's failure to be administered to maintain the highest practicable physical, mental and psychosocial well-being of each resident has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 07/24/13 and determined to exist on 03/22/13.<br><br>The facility provided an acceptable Allegation of Compliance on 08/02/13 and the Immediate Jeopardy was determined to be removed on 08/02/13 as alleged, prior to exit. The scope and severity was lowered to a "E" while the facility continues to implement and monitor quality assurance measures.<br><br>The findings include:<br><br>A review of the Kentucky Board of Nursing, Advisory Opinion Statement, (AOS) #14 Patient Care Orders, revised 02/2005, #5 revealed a nurse was obligated to not change an order of a physician/provider without the physician/provider's order to do so. Review of the Scope of Practice Determination Guidelines, revised 04/2005 revealed Licensed Practical Nurses would practice the administration of medication or treatment as authorized by a physician, physician assistant, dentist, or advanced practice registered nurse and as further authorized or limited by the board which is consistent with the National Federation of Licensed Practical Nurses or with standards of practice established by nationally accepted organizations of licensed practical nurses.<br><br>Review of the facility's policy regarding Medication Orders, not dated, revealed | F 490  | 3. The facility has initiated the following corrective actions to assure that identified issue does not reoccur as follows:<br><br>• Administrator at the onset of deficiency is no longer at the facility.<br>• New Administrator in-serviced by Quality Consultants, and Compliance Consultants regarding internal QA revised protocols and corrective action plan on 6-20-2013.<br><br>4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows:<br><br>The Administrator will report results of audits to the QA Committee monthly. The Quality Consultants will continue to assist the Administrator on audits and results under the direction of the QA Committee. The Quality Assurance Committee will review required audits and supportive documentation monthly to ensure the effectiveness of the compliance plan and make revisions as necessary on an ongoing basis<br><br>5. Completed by: | 8-28-2013                                    |



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

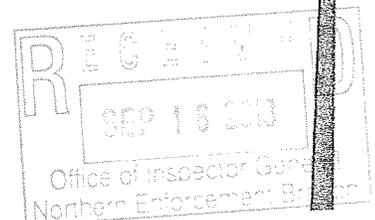
PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |   |                      |  |
|--|--|--|---|----------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 490  | <p>Continued From page 47</p> <p>medications were administered only upon the clear, complete and signed order of a person lawfully authorized to prescribe. Elements of the medication order included the name of the medication, strength of the medication, time or frequency of administration, route of administration, quantity or duration of therapy and diagnosis or indication for use.</p> <p>Interview and record review revealed facility licensed staff was changing physician medication orders and/or implementing medication orders without notifying or verifying the medication order with the physician.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 and the Assistant Director of Nursing (ADON) revealed they had not received any training in the physician order process with the facility's Electronic Medication Administration Record. Further interview with LPN #3 and the ADON revealed they knew writing orders was outside their scope of practice, and orders should not have been altered and/or implemented without physician verification. Interview with LPN #8 revealed she always wrote the orders for readmissions and did not verify the order with the attending physician for approval.</p> <p>Interview with the ADON, on 07/25/13 at 2:20 PM, revealed she was also the Staff Development Coordinator and conducted training for facility staff. She stated in orientation new nurses were trained in medication administration and medication error policies. The ADON stated the first of June and July 2013 an in-service was held on the resident admission process and covered the policy on physician orders and transcription errors.</p> | F 490  |   |                      |  |

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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
|--|---|--|---|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 490  | Continued From page 48<br><br>Interview with the Director of Nursing (DON), on 07/25/13 at 11:15 AM, revealed the nurse receiving the order from a local hospital should call the primary care physician to obtain approval for the medication ordered.<br><br>Further interview with the Director of Nursing (DON), on 07/25/13 at 2:40 PM, revealed the facility was in the process of doing chart reviews and any discrepancies which were identified should have been clarified prior to 07/22/13.<br><br>Interview with the Administrator, the Executive Director, the Director of Nursing and the Interim Director of Nursing, on 07/25/13 at 2:00 PM, revealed the 'root cause' of multiple medication errors in the facility was a 'computer glitch'. However, they did not have a facility plan to address the computer glitch.<br><br>Interview with the Administrator, the Executive Director, and the Interim Director of Nursing, on 08/02/13 at 2:15 PM, revealed the Executive Director came to the facility on 05/05/13 and Administrator came to the facility on 06/03/13. They stated they were aware of medication/transcription errors occurring in the facility and had addressed the problems with an audit process, but the errors continued to occur. The Executive Director stated it would not be acceptable for medication errors to continue at the rate they have been in order to maintain the highest well-being of it's residents and that the facility had not been administered in a manner to ensure the highest well-being of it's residents.<br><br>Review of the Acceptable Allegation of | F 490  |   |                      |  |



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

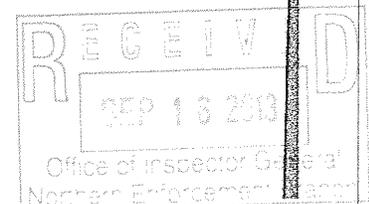
PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
|--|--|--|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 490 | <p>Continued From page 49</p> <p>Compliance (AOC) on 08/02/13, revealed the facility took the following immediate actions:</p> <ol style="list-style-type: none"> <li>1. Resident #1 was discharged to the hospital on 04/15/13 and did not return.</li> <li>2. For the facility to identify other residents that might be affected, the quality assurance consultants, under recommendation of the Quality Assurance Committee, completed a chart review that verified care plan were updated, beginning 07/01/13 through 07/31/13.</li> <li>3. In-services were conducted from 07/02/13 through 07/25/13. The in-services included topics of updating the care plan related to medication orders were conducted by the ADON, the Quality Consultant, and the Nursing House Supervisor under the direction of DON. The in-services were attended by all licensed practical nurses and registered nurses.</li> <li>4. The DON, ADON, Administrative Nurse Consultant and other professional consultants were conducting daily reviews of new admissions and daily orders to monitor for accurate processing of new orders and that care plans were updated accordingly.</li> <li>5. The DON was responsible for assuring the daily review process of physician orders and care plan updates as discussed were audited and reported for weekly review by the Quality Assurance Committee.</li> </ol> <p>The State Survey Agency validated the AOC on 08/02/13 prior to exit as follows:</p> <ol style="list-style-type: none"> <li>1. Record review revealed Resident #1 had been</li> </ol> | F 490 |  |  |
|-------|---|-------|--|--|



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

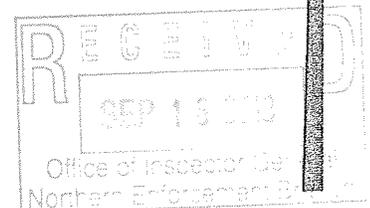
PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
|--|--|--|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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) | (X6) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

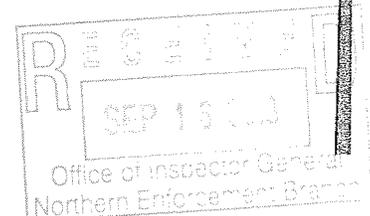
|       |  |       |  |  |
|-------|--|-------|--|--|
| F 490 | <p>Continued From page 50 discharged on 04/15/13 and not scheduled to return.</p> <p>2. Record review revealed chart audits were completed on 07/01/13 through 07/31/13 to ensure nursing care plans for residents were up to date. Interview with the DON, on 07/24/13 at 12:21 PM, revealed she reviewed the admission and readmission's orders daily to include physician orders and medication administration records. Interview with the interim DON (Consultant), on 07/26/13 at 12:30 PM, revealed she had completed all chart audits from 07/01/13 to 07/31/13 by looking at physician orders and medication administration records.</p> <p>3. Record review revealed an in-service was provided by ADON and Quality Consultant on 07/02/13 through 07/25/13, by review of the content of the in-service and review of the attendance logs for the in-service revealed all nursing staff attended the inservice. Interviews conducted on 08/02/13 with five (5) Licensed Practical Nurses: LPN #4 at 4:55 PM, LPN #2 at 6:05 PM, LPN #13 at 5:45 PM, LPN #14 at 6:33 PM, LPN #15 at 6:33 PM, two (2) Registered Nurses: RN #5 at 4:50 PM, and RN #4 at 5:57 PM, and three (3) Certified Medication Technicians (CMT)'s; CMT #1 at 11:22 AM, CMT #20 at 5:55 PM, and CMT #21 at 5:50 PM revealed they were educated on standards of practice, transcription process, communication to pharmacy, medication error process, and re-verification of orders in the EMAR system. Interview with LPN #3 at 08/01/13 at 1:37 PM, revealed she was educated on the transcription process, standards of practice, communication and ensuring re-verification of orders in the EMAR system. Interview with LPN #16 on</p> | F 490 |  |  |
|-------|--|-------|--|--|



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                      |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185388</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                      | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2013</b> |
|---|--|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MASONIC HOME OF LOUISVILLE</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>240 MASONIC HOME DRIVE<br/>MASONIC HOME, KY 40041</b>  |                      |   |
| (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 490   | Continued From page 51<br>08/02/13 at 6:33 PM, revealed she was also educated on checking for accuracy and making sure not to interpret the orders, but to write the orders exactly as the physician wrote them.<br><br>4. Record review revealed the Administrative staff conducted daily reviews of new admission and daily orders to monitor to ensure records were accurate. Interview with the DON, on 07/24/13 at 12:21 PM, revealed she reviewed the admission and readmission's orders daily. Interview with the ADON, on 07/24/13 at 10:35 AM, revealed she made copies of discharge summaries, written admission physician order sheet and then compared these documents to the computer to ensure items were correct and matched. Record review revealed the DON submitted all reviews to the Quality Assurance Committee.<br><br>5. Review of the care plan audit updates and weekly review information given to the QA committee revealed the documents were completed and reviewed by the Committee. Interview with the Interdisciplinary Team (IDT), (Nursing, Activities, Social Services and Dietary), on 08/02/13 at 2:03 PM, revealed the interdisciplinary team met daily to review audits for updates and weekly review of all information obtained through out the week. | F 490   |  |                      |   |
| F 514<br>SS=K   | 483.75(l)(1) RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and  | F 514   | 1. Residents # 1, #3, #5, #16, #29, #31, #35, and #H were identified as affected by the identified issue. The facility addressed the residents as follows:<br><br>Resident #1 was discharged from the facility to the hospital on 4-15-13 and did not return.<br>Resident #3 - a clarification order was obtained from the attending physician on 7/24/2013. |                      |   |



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

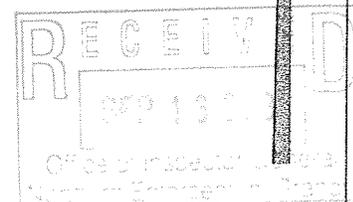
PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185388</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2013</b> |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MASONIC HOME OF LOUISVILLE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>240 MASONIC HOME DRIVE<br/>MASONIC HOME, KY 40041</b> |
|---|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

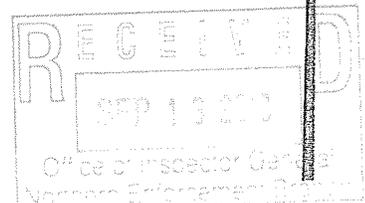
|       |   |       |   |  |
|-------|---|-------|---|--|
| F 514 | <p>Continued From page 52 systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on interview, record review, and review of facility policy it was determined the facility failed to have an effective system to maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete and accurately documented for seven (7) of thirty-eight (38) sampled Residents #1, #3, #5, #16, #29, #31, #35) and one (1) unsampled resident records (Unsampled Resident H).</p> <p>On 03/22/13 the facility admitted Resident #1 with orders for the antibiotic Cefazolin to be administered daily intravenously for twenty-eight (28) days due to an infection in the hip and elbow. The facility staff failed to administer the antibiotic daily for 28 days when the admitting Licensed Practical Nurse (LPN # 3) altered the physician's order by adding directions to administer the antibiotic at the dialysis center after treatment. This order was never clarified with the resident's physician and the dialysis center was not aware of the antibiotic therapy. Resident #1 did not receive the antibiotic for twenty-four (24) days (length of stay) of the ordered 28 days. On 04/15/13, the resident developed a mental status change and was transferred to the hospital and</p> | F 514 | <p>Resident #3 had received the Lovenox per the physician order as indicated on the medication administration record. The facility disagrees that this is a breach of professional standard by the nurse involved. <i>Physician's was order signed on 8/5/2013.</i> Resident #5 - on 6-11-13 the nurse practitioner ordered Allpurinol in response to a pharmacy recommendation. The order was discontinued on 7-9-13 by the nurse practitioner due to resident refusal of medication. The facility disagrees that this is a breach of professional standard by the nurse involved.</p> <p>Resident #16 - attending physician signed the order for Levaquin on 7/9/2013. Resident #16 did receive the medication under physician order after hospital discharge. The facility disagrees that this is breach of professional standard by the nurse involved.</p> <p>Resident #29 - an order for Lasix 20mg was obtained from the nurse practitioner on 7-17-2013 and signed by the attending physician on 7-18-13. The facility disagrees that this is a breach of professional standard by the nurse involved.</p> <p>Resident #31 - resident #31 40 mg Lasix order reviewed by physician on 7/26/2013.</p> <p>Resident #35 - a clarification order was obtained on 7-29-2013 to correct the administration record. The facility disagrees that this is a breach of professional standard by the nurse involved. <i>EMAR corrected on 7/16/2013.</i></p> <p>Resident #H - on 4-22-13 floor RN completed the transcription of the order for Melatonin. The facility disagrees that this is a breach of professional standard by the nurse involved. <i>Incident report made on 4/22/2013 and physian notified on 4/22/2013</i></p> <p>2. To identify other residents that might be affected, the Quality Assurance Consultants, under recommendation of the Quality Assurance Committee (DON, ADON, Administrator, ANC), completed a chart review beginning 7/1/13 through 7/31/13 that included review of current residents' physician orders and medication administration records.</p> <p>• For 100% resident review, Nursing Reviews that included review of current residents' physician orders and medication administration records as documented from the original physician order source, were completed between 7/1/2013 and</p> |  |
|-------|---|-------|---|--|



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

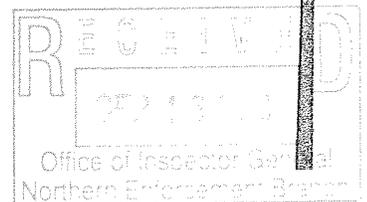
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185388</b>   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                              |  | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2013</b> |
|---|---|---|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MASONIC HOME OF LOUISVILLE</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>240 MASONIC HOME DRIVE<br/>MASONIC HOME, KY 40041</b> |  |   |
| (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 514   | <p>Continued From page 53</p> <p>admitted with an impression of Toxic Metabolic Encephalopathy secondary to gram-positive cocci Septicemia with Bacteremia, likely a recurrence of underlying MSSA Sepsis. The resident did not return to the facility, but was transferred to another local Long Term Care facility and expired on 05/02/13.</p> <p>In addition Residents #3, #5, #16, #29, #31, #35, and Unsampled Resident H had transcription errors related to medication orders.</p> <p>The facility's failure to have a system in place to ensure the accuracy of the medical record has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 07/24/13 and determined to exist on 03/22/13.</p> <p>The facility provided an acceptable Allegation of Compliance on 08/02/13 and the Immediate Jeopardy was determined to be removed on 08/02/13 as alleged, prior to exit on 08/02/13. 42 CFR 483.75 Administration (F514) scope and severity was lowered to a "E" while the facility continues to implement and monitor quality assurance measures.</p> <p>The findings include:</p> <p>Record review of the Health Information Management and Procedure Policy, revised 03/2013, revealed medical records utilized in the facility consisted of both paper and electronic documentation. Electronically maintained medical records follow the same guidelines for completion, accuracy and privacy as those maintained on paper. The residents record is a legal, factual and objective recording of the</p> | F 514   | <p>7/25/2013 by Director of Nursing (DON), Assistant Director of Nursing (ADON), Administrative Nurse Consultants (ANC), and Nursing Consultants s on all existing residents' orders, new orders, and new admissions' orders.</p> <ul style="list-style-type: none"> <li>All transcription orders were reviewed by DON, ADON, and ANC upon the recommendations of the Pharmacy medication regimen order review.</li> </ul> <p>3. The facility has initiated the following corrective actions to assure that identified issue does not reoccur as follows:</p> <ul style="list-style-type: none"> <li>In-services were conducted from 7/2/13 through 7/25/13. The in-services were conducted by the ADON, the Quality Consultants, and the Nursing House Supervisor under the direction of DON. The in-services were attended by all licensed practical nurses and registered nurses and included emphasis on verification of orders with the attending physician, transcribed accurately per the original order source and the entering of orders into the facility EMAR system correctly, and that the pharmacy notification protocol be followed. A question and answer period was incorporated in each in-service session to assure comprehension of education presented.</li> <li>Consulting pharmacy conducted in-services for all Licensed Practical Nurses, Registered Nurses, and Agency Nurses beginning on 7/26/13 through 8/1/13. These in-services included instruction on professional standards of practice related to transcription of physician orders, physician order transcription process, communication to pharmacy, medication error process, and re-verification of orders into the EMAR system and medication administration records. A question and answer period was incorporated in each in-service session to assure comprehension of education presented.</li> <li>7/31/2013 DON in-serviced nursing House Leaders and ADON regarding record reconciliation, transcript and medication errors identification and reporting protocol.</li> <li>8/14/2013 DON in-served all licensed nurses CMTs and agency nurses regarding scope of nursing practice, physician order protocol, medication error identification and reporting protocol, and physician order reconciliation protocol.</li> </ul> |   |



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

|   |   |   |   |                      |   |
|---|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                      |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185388</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MASONIC HOME OF LOUISVILLE</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>240 MASONIC HOME DRIVE<br/>MASONIC HOME, KY 40041</b>   |                      |   |
| (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 514   | <p>Continued From page 54</p> <p>residents condition, problems, plans of care and outcomes.</p> <p>1. Review of Resident #1's closed clinical record revealed the facility admitted the resident on 03/22/13 with diagnoses of Sepsis (Methicillin Sensitive Staphylococcus Aureus MSSA), Bilateral Infected Hip Prosthesis, Hypertension, Coronary Artery Disease, Spinal Stenosis, Low Back Pain, Urinary Incontinence, Left Hip Pain, Status Post Left Hip Replacement, Infection of Olecranon Bursa (back of the elbow) and Acute Kidney Injury.</p> <p>Review of Resident #1's Discharge Summary, dated 03/22/13, revealed Resident #1 was to receive Cefazolin two (2) grams into the vein daily for twenty-eight (28) days.</p> <p>Review of Resident #1's POS, dated 03/22/13, revealed the Cefazolin order was written to read: Cefazolin 2g IV QD (after HD on HD days).</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 07/02/13 at 3:56 PM, revealed she initiated Resident #1's admission Physician Order Sheet (POS) and documented on the POS that Resident #1 was to receive Cefazolin two (2) grams daily (QD), after hemodialysis (HD) on HD days. LPN #3 stated she should have not added to the order the (after HD on HD days), since she did not obtain an order for the antibiotic to be given on dialysis days.</p> <p>Interview with the Physician, on 07/05/13 at 1:35 PM, revealed he did not remember instructing LPN #3 to give the antibiotic medication on dialysis days and after the dialysis treatment.</p> | F 514   | <p>4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows:</p> <ul style="list-style-type: none"> <li>The Director of Nursing, Assistant Director of Nursing, Administrative Nurse Consultants, and other professional Consultants s are conducting daily reviews of new admissions and daily orders to monitor that the transcription process is performed accurately. This Quality Assurance process was revised on 7/1/2013 per recommendation of the Quality Assurance Committee (DON, ADON, Administrator, ANC). DON is submitting all reviews to the Quality Assurance Committee (DON, ADON, Administrator, ANC) weekly for review to ensure effectiveness of the allegation of compliance.</li> <li>The Director of Nursing will make a monthly report of the audits to the full Quality Assurance Committee for assessment and recommendation. The audit schedule will be continued until revised by the Quality Assurance Committee. The Administrator will be responsible to assure that the compliance plan is monitored by the Quality Assurance Committee monthly. Administrator will be responsible for monitoring to ensure effectiveness of the compliance plan.</li> <li>Also the Quality Assurance Committee (included Medical Director, DON, ADON, Administrator, ANC) met on the following dates: 7/1, 7/2, 7/3, 7/4, 7/5, 7/8, 7/9, 7/11, 7/12, 7/15, 7/18, 7/22, 7/24, 7/25, and 7/29 to assess reviews and make recommendations. These reviews were assessed by the Quality Assurance Committee (DON, ADON, Administrator, ANC) and will continue to be monitored monthly to ensure effectiveness of the allegation of compliance.</li> </ul> <p>5. The Quality Assurance Committee will review required audits and supportive documentation monthly to ensure the effectiveness of the compliance plan and make revisions as necessary on an ongoing basis completed by:</p> | 8-28-2013            |   |



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

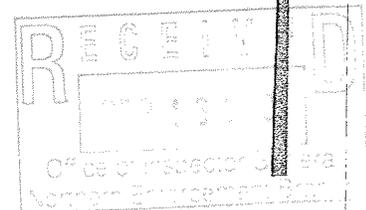
PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185388</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2013</b> |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MASONIC HOME OF LOUISVILLE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>240 MASONIC HOME DRIVE<br/>MASONIC HOME, KY 40041</b> |
|---|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

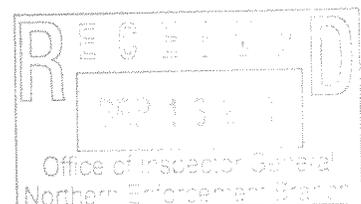
|       |  |       |  |  |
|-------|--|-------|--|--|
| F 514 | <p>Continued From page 55</p> <p>Interview with the House Leader, on 07/05/13 at 12:19 PM, revealed she was to conduct chart checks on her unit daily. However, the House Leader stated she did not complete a chart check of Resident #1's Physician orders.</p> <p>Interview with the ADON, on 07/05/13 at 1:10 PM, revealed when she initially looked at Resident #1's order all she could see was the HD and did not notice the QD (daily).</p> <p>2. Review of the closed record for Unsampled Resident H revealed the resident was ordered to receive Melatonin 3 milligrams (mg) at night (HS) on 04/18/2013. The Melatonin order was not placed onto the Medication Administration Record (MAR) until 04/22/13. Therefore, Resident H did not receive his/her medication until four (4) days later.</p> <p>Review of the Medication Error Report revealed the error was discovered through a chart audit on 07/01/13 to 07/05/13; however, an investigation was not completed as to what the root cause was for the medication not being transcribed onto the MAR.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 07/23/13 at 10:40 AM, revealed there was no documented investigation report for the medication error. The investigation report would document who reported the incident, whom was involved, Notifications to the House Leader, ADON, Director of Nursing (DON) with date and time. Was their any property involved, the activity time and who the report was prepared by. In addition there was no follow up provided to see who followed up with the medication error. The ADON stated Resident H's record was not kept</p> | F 514 |  |  |
|-------|--|-------|--|--|



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |   |                      |  |
|--|--|--|---|----------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 514  | Continued From page 56<br>as accurate as it should of been.<br><br>Interview with the DON, on 07/23/13 at 10:01 AM, revealed she did not complete an investigation into Resident H's medication error. She stated she thought the House Leader would of completed one. The DON stated she did print out incident reports, but did not have one for Resident H.<br><br>3. Review of the clinical record for Resident #31 revealed the resident was readmitted to the facility on 07/02/13 with diagnoses to include end stage Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF). Review of the readmission physician order sheet (POS) dated 07/02/13 revealed Resident #31 had Lasix (a drug used to remove extra fluid) 40 milligrams by mouth daily ordered. Further review of Resident #31's physician orders revealed a telephone order dated 07/12/13 to increase Lasix to 40 milligrams daily and to add Lasix 20 milligrams by mouth daily for three (3) days. Review of the Electronic Medication Administration Record (EMAR) revealed the Lasix 40 milligram order was on the EMAR twice (a duplicated order) and the duplicated Lasix 40 milligrams was documented as having been given twice on 07/13/13, 07/14/13 and 07/15/13. Review of the notes attached to the EMAR revealed the Lasix 40 milligram duplicated dose was not given on 07/15/13 as the Certified Medication Technician (CMT) assigned to administer those medications had recognized the duplicated order. However, the resident received a duplicate dose on 07/16/13. Review of a medication error incident report presented for the Lasix duplicated order for Resident #31 revealed no contact was made to the resident's physician, | F 514  |   |                      |  |



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

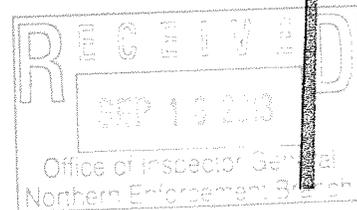
PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185388</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2013</b> |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MASONIC HOME OF LOUISVILLE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>240 MASONIC HOME DRIVE<br/>MASONIC HOME, KY 40041</b> |
|---|---|

| (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 514 | <p>Continued From page 57</p> <p>there was no date on the form as to when it was completed and there was no indication of any follow-up for the error. Review of Resident #31's laboratory values revealed no concerns of too much fluid loss.</p> <p>4. Review of the medical record for Resident #16 revealed the resident returned from an Emergency Room (ER) visit on 07/06/13 at a local hospital with an order for Levaquin 500 mg daily for ten (10) days. The local hospital sent a prescription written and signed by the ER physician. The order was present on the Medication Administration Record and the medication was given as ordered. There was no verification of the order with the attending physician for the order or evidence in the nurse's notes that the attending physician was notified.</p> <p>Interview with LPN #8, on 07/25/13 at 12:05 PM, revealed she did not verify the order with the physician and she further stated, she never verifies orders with the physician. In addition, when LPN #8 wrote the order on the physician order form, the ER physician's name was omitted. The order was written per the ER physician. The ER physician's name was printed on the prescription and the prescription was signed.</p> <p>Interview with the Pharmacist, on 07/31/13 at 2:55 PM, revealed it was not the pharmacy's responsibility to verify that the physician had approved the order(s) the pharmacy fills, all orders with valid prescription orders are filled and they do not check that the order has been approved by the attending physician.</p> <p>5. Review of the clinical record for Resident #29 revealed the facility admitted the resident</p> | F 514 |  |  |
|-------|--|-------|--|--|



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

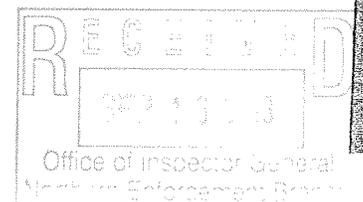
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
|--|--|--|---|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 514  | <p>Continued From page 58</p> <p>06/28/13 with diagnoses of Chronic Obstructive Pulmonary Disease (COPD) and Hypertension (HTN). On admission the resident had a physician order for Lasix 20 mg every morning. On 07/14/13 the physician ordered to increase Lasix to 40 mg daily for five (5) days for edema. A nurse wrote an order, on 07/15/13, for Lasix 20 mg daily to begin on 07/17/13 without the designation of the physician who gave the clarification of the medication order. Additionally, the order was not signed by the physician.</p> <p>Review of the EMAR for July 2013 revealed Lasix 20 mg daily, with a start date of 07/17/13, was documented as administered to Resident #29. The EMAR reflected administration daily, beginning 07/17/13.</p> <p>The facility did not provide an incident report, medication error report, or investigation for Resident #29's Lasix medication error.</p> <p>6. Review of the medical record for Resident #3 revealed the facility admitted the resident on 06/27/13 with diagnosis of Septicemia related to their dialysis catheter, End Stage Renal Disease requiring hemodialysis, Peripheral Vascular Disease, Thrombocytopenia, Diabetes, Atrial Fibrillation, Hepatitis C, Hypertension, Degenerative Disc Disease, and Anemia. A review of the Admission orders, dated 06/27/13, revealed an order for Lovenox 30 mg subcutaneously for Deep Vein Thrombosis (DVT) prophylaxis. There was no frequency (or how often the drug should be given) included in the admission order. Review of the Electronic Medication Administration Record (EMAR) revealed the order was placed in the electronic system to be given daily despite no physician's</p> | F 514  |   |                      |  |



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
|--|--|--|---|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 514  | <p>Continued From page 59 order clarifying the medication.</p> <p>Review of the pharmacy initial medical record review, dated 06/27/13, revealed a request to include a frequency and stop date/parameter for the Lovenox. Further review of the resident's medical record revealed an order clarification for Lovenox 30 mg subcutaneously daily written on 07/24/13 at 9:00 PM; however, the stop date/parameter was not included in the order clarification.</p> <p>Interview with House Leader #1, on 07/25/13 at 9:45 AM, revealed when entering an order into the EMAR system, all order components have to be complete; therefore, when the nurse entering the orders reached the frequency section, something had to be entered in order to continue in the EMAR system. Continued interview with the House Leader revealed she completed an audit of all new admissions on the Clinical Coordinator 24 Hour Chart Audit form and turn it into the Director of Nursing (DON). However, further interview with the House Leader, on 07/25/13 at 3:37 PM, revealed the facility could not locate Resident #3's audit and stated one was never completed.</p> <p>7. Record review revealed the facility admitted Resident #35, on 06/24/13 with the diagnoses of Dementia with Behavior, Osteoarthritis, Anxiety, Gastric Reflux, Vitamin B-12 Deficiency, and Coronary Heart Disease. Review of the admission orders revealed the physician ordered Vitamin B-12 1000 microgram (mcg) orally to be given every day. However, review of the EMAR revealed the order was entered, on 06/25/13, by the facility as Vitamin B-12 250 mcg orally every day. The resident received the 250 mcg every</p> | F 514  |   |                      |  |



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

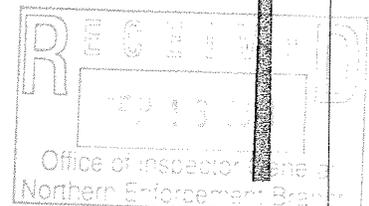
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
|--|--|--|---|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 514  | <p>Continued From page 60</p> <p>day. A clarification order was not obtained until 07/29/13, thirty-four (34) days after the medication was entered incorrectly into the EMAR computer system.</p> <p>Interview with Licensed Practical Nurse (LPN) #14, on 08/01/13 at 3:40 PM, revealed she did remember completing the admission for Resident #35, but did not remember the resident's ordered Vitamin B-12 dosage. The LPN revealed no one had told her of an order entry error, or questioned the admission orders.</p> <p>Interview with ADON, on 08/01/13 at 3:05 PM, revealed Resident #35's medication error was discovered with the audits that were taking place in the building on 07/01/13 to 07/05/13 but a clarification order was not obtained until 07/29/13.</p> <p>8. Review of the clinical record for Resident #5 revealed the facility re-admitted the resident on 12/13/12 with diagnoses of Dementia and Gout. The facility assessed the resident on 11/19/12 as cognitively impaired with a Brief Interview Mental Status (BIMS) of four (4). The POS on 12/13/12 revealed the resident was to receive Allopurinol 200 mg every bedtime for Gout. Additionally, the POS for January 2013 through May 2013 revealed the Allopurinol was not listed to be administered. Review of the physician orders revealed there was no discontinue (D/C) order for the Allopurinol for Resident #5.</p> <p>Review of Resident #5's electronic record revealed a facility staff member entered Allopurinol 200 mg to be given every bedtime into the electronic record to start the medication on 12/13/12 at 10:03 PM and stop the medication on 12/14/12 at 8:00 PM. The EMAR, beginning</p> | F 514  |   |                      |  |



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
|--|---|--|---|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 514  | <p>Continued From page 61</p> <p>12/13/12 and ending 06/10/13, revealed the resident did not receive the Allopurinol medication until 06/11/13 when the medication was placed on the POS and EMAR. The EMARs for January 2013 through May 2013 did not have the Allopurinol listed to be administered to the resident.</p> <p>On 07/25/13 at 1:18 PM, interview with Licensed Practical Nurse (LPN) #6 revealed if the medication was not listed on the EMAR then the medicine would not be administered to the resident. The LPN stated the nurse receiving the physician order was responsible to enter the orders into the EMAR and the Nurse Leader on the unit was responsible to verify the orders entered into the EMAR were correct. The LPN stated the nurse on the next shift should check the information if the House Leader was not available.</p> <p>Interview, on 07/25/13 at 1:55 PM and 2:40 PM, and on 07/26/13 at 9:48 AM, 12:20 PM, and 2:52 PM, with the Director of Nursing (DON) revealed Resident #5's Allopurinol had not been D/C'd by the physician after the resident's readmission to the facility 12/13/12 and when it was stopped in the EMAR on 12/14/12. She stated the House Leader was responsible to audit resident charts. The DON stated Resident #5 was on a long term care unit which was audited the previous evening; however, she could not recall if anyone audited the resident's chart.</p> <p>Interview, on 07/26/13 at 3:23 PM and 08/01/13 at 3:07 PM, with the Nurse Consultant, now the Interim Director of Nursing (DON) revealed neither a facility incident report nor a medication error report for Resident #5's Allopurinol were</p> | F 514  |   |                      |  |



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

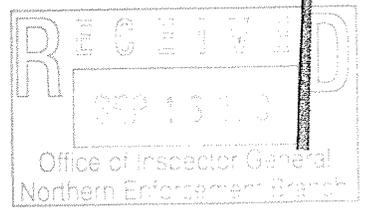
PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185388</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2013</b> |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MASONIC HOME OF LOUISVILLE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>240 MASONIC HOME DRIVE<br/>MASONIC HOME, KY 40041</b> |
|---|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

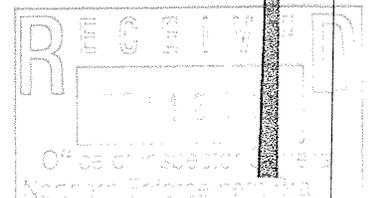
|       |   |       |  |  |
|-------|---|-------|--|--|
| F 514 | <p>Continued From page 62 completed. The Interim DON stated an incident report still had not been completed and should have been completed when the medication transcription error was discovered. The Interim DON stated the system had failed along the way.</p> <p>Interview, on 07/26/13 at 3:23 PM, with the Administrator revealed entering information into the electronic chart could have a data entry error. She stated the facility was learning how the computer can cause data entry errors.</p> <p>Interview with the Director of Nursing (DON), on 07/05/13 at 1:41 PM, revealed it was the DON's and the ADON's responsibility to ensure the chart checks were completed. The DON stated the House Leaders should be checking the orders daily. The DON stated the House Leaders should compare the discharge summary, POS and the computer system to ensure all are documented appropriately. The DON stated she had not completed random chart checks since before the medication error occurred.</p> <p>Review of the Acceptable Allegation of Compliance (AOC) on 08/02/13, revealed the facility took the following immediate actions:</p> <ol style="list-style-type: none"> <li>1. Resident #1 was discharged to the hospital on 04/15/13 and did not return.</li> <li>2. For the facility to identify other residents that might be affected, the quality assurance consultants, under recommendation of the Quality Assurance Committee, completed a chart review beginning 07/01/13 through 07/31/13 that included verification of care plan updates.</li> <li>3. In-services were conducted from 07/02/13</li> </ol> | F 514 |  |  |
|-------|---|-------|--|--|



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |                      |  |
|--|---|--|---|----------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 514  | <p>Continued From page 63 through 07/25/13. The in-services were conducted by the ADON, the Quality Consultant, and the Nursing House Supervisor under the direction of DON. The in-services were attended by all licensed practical nurses and registered nurses and incorporated updating the care plan related to medication orders.</p> <p>4. The DON, ADON, Administrative Nurse Consultant and other professional consultants were conducting daily reviews of new admissions and daily orders to monitor that care plans were updated accordingly.</p> <p>5. The DON was responsible for assuring the routine care plan updates and review process discussed were audited and reported for weekly review by the Quality Assurance Committee.</p> <p>The State Agency Validated the AOC on 08/02/13 prior to exit as follows:</p> <p>1. The State Agency validated by review, Resident #1 had been discharged on 04/15/13 and not scheduled to return.</p> <p>2. The State Agency validated by record review chart audits that were completed on 07/01/13 through 07/31/13 by reviewing records of the chart audits on 08/02/13. Record review of thirty-eight (38) records revealed nursing care plans for Residents were up to date. Interview with the DON, on 07/24/13 at 12:21 PM, revealed she reviewed the admission and readmission's orders daily to include physician orders and medication administration records. Interview with the interim DON (Consultant), on 07/26/13 at 12:30 PM, revealed she had completed all chart audits by looking at physician</p> | F 514  |   |                      |  |



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

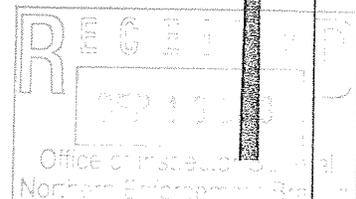
PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
|--|--|--|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

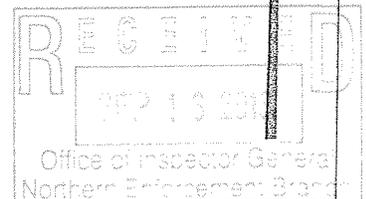
|       |   |       |  |  |
|-------|---|-------|--|--|
| F 514 | <p>Continued From page 64 orders and medication administration records.</p> <p>3. The State Agency validated an in-service was provided by ADON and Quality Consultant on 07/02/13 through 07/25/13, by review of the content of the in-service and review of the attendance logs for the in-service. Interviews conducted on 08/02/13 with five (5) Licensed Practical Nurses, two (2) Registered Nurses and three (3) Certified Medication Technicians (CMT)'s revealed they were educated on standards of practice, transcription process, communication to pharmacy, medication error process, re-verification of orders in the EMAR system. Interview with LPN #3 at 08/01/13 at 1:37 PM, revealed she was educated on the transcription process, standards of practice, communication and ensuring re-verification of orders in the EMAR system. Interview with LPN #16 on 08/02/13 at 6:33 PM, revealed she had attended the in-service that was provided by the ADON and was instructed on ensuring the care plan was updated with accurate information. LPN #16 was also educated on checking for accuracy and making sure as to not interpret the orders, but to write the orders exactly as the physician wrote them. Interview with LPN #17, on 08/02/13 at 6:33 PM, revealed he was in-serviced by pharmacy on communication and pharmacy notification protocol.</p> <p>4. The State Agency validated by record review, the Administrative staff were conducting daily reviews of new admission and daily orders to monitor daily orders and care plans to ensure records were up to date. Interview with the DON, on 07/24/13 at 12:21 PM, revealed she reviewed the admission and readmission's orders daily and ensured the care plan was accurate to the</p> | F 514 |  |  |
|-------|---|-------|--|--|



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                      |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185388</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                      | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2013</b> |
|---|---|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MASONIC HOME OF LOUISVILLE</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>240 MASONIC HOME DRIVE<br/>MASONIC HOME, KY 40041</b>  |                      |   |
| (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 514   | Continued From page 65<br>medications that were provided. Interview with the ADON, on 07/24/13 at 10:35 AM, revealed she made copies of discharge summaries, written admission physician order sheet and then compared to the computer to ensure items were correct and matched. The State Agency validated the DON submitted all reviews to the Quality Assurance Committee through record review.<br><br>5. The State Agency validated by review of the care plan audit updates and weekly review information given to the QA committee were completed and reviewed by the Committee. Interview with the Interdisciplinary Team (IDT), on 08/02/13 at 2:03 PM, revealed the interdisciplinary team met daily to review audit updates and weekly to review all information learned through out the week. | F 514   |  |                      |   |
| F 520<br>SS=K   | 483.75(o)(1) QAA<br>COMMITTEE-MEMBERS/MEET<br>QUARTERLY/PLANS<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee   | F 520   | 1. Residents # 1, #3, #5, #6, #16, #29, #31, #35, and #H were identified as affected by the identified issue. The facility addressed the residents as follows:<br><br>Resident #1 was discharged from the facility to the hospital on 4-15-13 and did not return.<br>Resident #3 - a clarification order was obtained from the attending physician on 7-24-2013. Resident #3 had received the Lovenox per the physician order as indicated on the medication administration record. The facility disagrees that this is a breach of professional standard by the nurse involved. <i>Physician's order was signed on 8/5/2013.</i><br>Resident #5 - on 6-11-13 the nurse practitioner ordered Allpurinol in response to a pharmacy recommendation. The order was discontinued on 7-9-13 by the nurse practitioner due to resident refusal of medication. The facility disagrees that this is a breach of professional standard by the nurse involved.<br>Resident #6 - the nursing staff conducted the resident's tuberculin testing which was negative. The facility disagrees that this is a breach of professional standard by the nurse involved. |                      |   |



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
|--|--|--|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 520 Continued From page 66 except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review and facility policy review, it was determined the facility's Quality Assurance Committee failed to identify quality deficiencies, develop a plan of action, and implement the plan of action to correct medication errors. Eight (8) of thirty-eight (38) sampled records (Residents #1, #3, #5, #6, #16, #29, #31, #35) and one (1) of eight (8) unsampled records (Unsampled Resident H) were identified to have a medication/transcription errors that the facility failed to thoroughly investigate or follow-up to ensure corrective actions to prevent further incidents. (Refer to F281, F333, F514 and F490)

The facility's failure to have an effective system in place to ensure the Quality Assurance Program/Committee identified quality deficiencies, developed plans of action, and implemented the plans of action to correct medication/transcription errors was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 07/24/13 and determined to exist on 03/22/13.

The facility provided an acceptable Allegation of Compliance on 08/02/13 and the Immediate

F 520 Resident #16 - attending physician signed the order for Levaquin on 7-9-2013. Resident #16 did receive the medication under physician order after hospital discharge. The facility disagrees that this is breach of professional standard by the nurse involved. Resident #29 - an order for Lasix 20mg was obtained from the nurse practitioner and signed by the attending physician on 7-18-13. The facility disagrees that this is a breach of professional standard by the nurse involved.

Resident #31 - resident #31 40 mg Lasix order reviewed by physician on 7/26/2013. *EMAR corrected on 7/16/2013.*

Resident #35 - a clarification order was obtained on 7-29-2013 to correct the administration record. The facility disagrees that this is a breach of professional standard by the nurse involved.

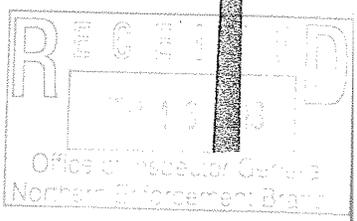
Resident #H - on 4-22-13 floor RN completed the transcription of the order for Melatonin. The facility disagrees that this is a breach of professional standard by the nurse involved.

*Incident report made on 4/22/2013 and physician notified on 4/22/2013.*

- The QA committee reviewed the circumstances surrounding the resident examples and the corrective action taken in response thereto. Further, the facility also examined the facility systems involving the issues identified in the statement of deficiencies and oversaw the corrective actions taken.

2. To identify other residents potentially affected by the identified issue, the facility initiated the following corrective actions:

- The Administrator initiated a new quality assurance program with the Quality Assurance Committee effective 6-20-13 to provide ongoing quality assessment and assurance to identify deficiencies, develop and implement plans of action to correct deficiencies. Deficiencies are identified through QA audits and compliance. Action plans are developed based on audit compliance and monitored at specified durations under QA recommendations. Action plans are reviewed and monitored monthly to ensure the effectiveness of the action plan and make revisions as necessary on an ongoing basis.



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

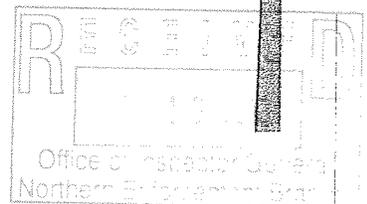
PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
|--|--|--|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 520 | <p>Continued From page 67</p> <p>Jeopardy was determined to be removed on 08/02/13 as alleged, prior to exit. The scope and severity was lowered to a "E" while the facility continues to implement and monitor quality assurance measures.</p> <p>The findings include:</p> <p>Review of the Facility Accident and Incidents: Report, Investigation, Follow-up and Disposition policy, effective 12/2007, revealed the facility defined an accident/incident as an event, occurrence, or happening that may produce an actual or potential undesirable outcome. Accidents/incidents defined in the policy included medication errors. Per the policy if an accident/incident occurred, the facility would strive to prevent such an occurrence from happening again. A thorough investigation and follow-up would be completed within five (5) working days. All occurrences would be reviewed by the Administrator, Director of Nursing (DON), Medical Director and Quality Assurance Committee. A final disposition of the accident/incident would be documented.</p> <p>Review of the Medication Error Policy and Procedure policy, reviewed 04/2008, revealed for all significant and non-significant medication errors, the facility would complete a Medication Error Report located in the facility's computer system.</p> <p>Record review revealed eight (8) of thirty-eight (38) sampled residents and one (1) unsampled resident were identified to have a medication/transcription error that was not investigated and no follow-up was completed.</p> | F 520 | <ul style="list-style-type: none"> <li>Quality Assurance Consultants, under recommendation of the Quality Assurance Committee (DON, ADON, Administrator, ANC), completed a chart review beginning 7/1/13 through 7/31/13 that included review of current residents' physician orders and medication administration records.</li> <li>For 100% resident review, Nursing Reviews that included review of current residents' physician orders and medication administration records as documented from the original physician order source, were completed between 7/1/2013 and 7/25/2013 by Director of Nursing (DON), Assistant Director of Nursing (ADON), Administrative Nurse Consultants (ANC), and Nursing Consultants on all existing residents' orders, new orders, and new admissions' orders.</li> <li>All transcription orders were reviewed by DON, ADON, and ANC on 7/25/2013 upon the recommendations of the Pharmacy medication regimen order review.</li> </ul> <p>3. The facility has initiated the following corrective actions to assure that identified issue does not reoccur as follows:</p> <p>In-services conducted at the facility from 7/2/13 through 8/1/13.</p> <ul style="list-style-type: none"> <li>In-services were conducted from 7/2/13 through 7/25/13. The in-services were conducted by the ADON, the Quality Consultants, and the Nursing House Supervisor under the direction of DON. The in-services were attended by all licensed practical nurses and registered nurses and included emphasis on verification of orders with the attending physician, transcribed accurately per the original order source and the entering of orders into the facility EMAR system correctly, and that the pharmacy notification protocol followed. A question and answer period was incorporated in each in-service session to assure comprehension of education presented.</li> </ul> |  |
|-------|---|-------|--|--|



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
|--|--|--|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 520 Continued From page 68

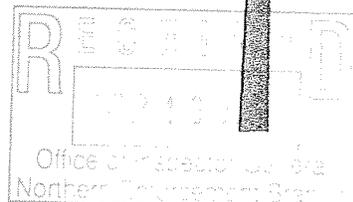
Interview with the House Leaders revealed they were responsible for conducting checks weekly on all of the residents in the homes they supervised. The House Leaders stated two weeks before the end of the month the residents' physician orders were printed, then the physician and the House Leaders received a copy of the order. The physician signed the orders and the House Leaders checked the orders to make sure there were no discrepancies. However, the House Leaders stated when they had to work the floor and complete chart checks, they could not do the chart checks as effectively.

Interview with the Assistant Director of Nursing (ADON), on 07/05/13 at 1:10 PM, revealed the monthly change overs were completed by the House Leaders at the beginning of each month. The ADON was not sure of what was actually compared when the House Leaders completed the chart checks and stated she had not received training on how to complete a chart check. The ADON stated the House Leaders should be reviewing all the orders daily and the House Leader should ensure what was transcribed matched the computer. The ADON stated no one was auditing the Admission/Readmission check list (used by the facility to ensure all documents are available on admission and are completed and faxed to the MD and pharmacy) to ensure the check list was completed. Per interview she was not instructed to do random chart checks to ensure the House Leaders were doing what they were suppose to be doing and was not sure if she should be doing them.

Interview with the DON, on 07/05/13 at 1:41 PM, revealed the House Leader was responsible to do

F 520

- Consulting pharmacy conducted in-services for all Licensed Practical Nurses, Registered Nurses, and Agency Nurses beginning on 7/26/13 through 8/1/13. These in-services included instruction on professional standards of practice related to transcription of physician orders, physician order transcription process, communication to pharmacy, medication error process, and re-verification of orders into the EMAR system and medication administration records. A question and answer period was incorporated in each in-service session to assure comprehension of education presented.
- 7/31/2013 DON in-serviced nursing House Leaders and ADON regarding record reconciliation, transcript and medication errors identification and reporting protocol.
- 8/14/2013 DON in-served all licensed nurses CMTs and agency nurses regarding scope of nursing practice, physician order protocol, medication error identification and reporting protocol, and physician order reconciliation protocol.
- The orientation process and checklist for newly hired licensed nurses was revised by the Director of Nursing, the Assistant Director of Nursing, and the Administrative Nursing Consultants. The orientation process and checklist was reviewed and approved by the Quality Assurance Committee (DON, ADON, Administrator, ANC) on 7/12/13. Quality Assurance Committee (DON, ADON, Administrator, ANC) monitored and reviewed the process for new hires on 7/22/2013 and will continue to assess and make revisions as necessary to ensure effectiveness of the allegation of compliance.
- Agency Nurse orientation process was developed by the DON, ADON, ANC, and nursing Consultants and approved by the Quality Assurance Committee (DON, ADON, Administrator, ANC) on 7/1/2013. Quality Assurance Committee (DON, ADON, Administrator, ANC) monitored and reviewed the process for new agency hires and will continue to assess and make revisions as necessary to ensure effectiveness of the allegation of compliance.



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
|--|--|--|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 520

Continued From page 69  
chart checks at the end of each month. The DON stated she and the ADON were responsible to ensure the chart checks were completed monthly. The DON stated she did not think there was an actual procedure for the end of the month chart checks, but that the orders should be checked daily. The DON stated the House Leader should take the discharge summary and the physician order sheet and check it against each other and make sure the medications were placed in the computer system appropriately.

Further interview with the ADON, on 08/01/13 at 1:21 PM, revealed the nursing staff was not responsible to complete incident reports. Nurses were taught to inform the House Leader of a medication error and the House Leader was responsible to complete the incident report. The Director of Nursing (DON) was then responsible to print the incident reports, but she was unsure how often the reports were printed. Per interview, if a House Leader did not complete an incident report then they would not know if there was a medication error. The ADON stated she conducted the training's in the facility, but she had not trained the House Leaders in regards to their role in completing incident reports. The ADON stated if there was no incident report then there was no follow up either. The ADON stated she had not looked at the form before, nor had she been asked to complete the form or print the form for morning meetings.

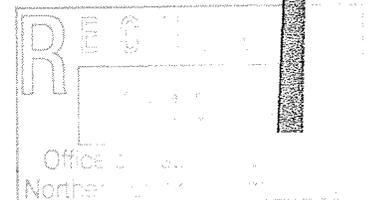
Interview with the DON, on 07/23/13 at 11:53 AM, revealed she printed incident reports in the morning prior to the morning meeting. The DON stated the incident reports were mostly about falls, not medication errors.

F 520

- Administrator at the onset of deficiency is no longer employed at the facility.
- The Administrator educated the QA Committee on the newly implemented Quality Assurance Process including QA audit calendars, policy reviews, actions plans, and quality assurance and performance improvement procedure including action plan development, monitoring, and reporting.

4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows:

- The Director of Nursing, Assistant Director of Nursing, Administrative Nurse Consultants, and other professional Consultants s are conducting daily reviews of new admissions and daily orders to monitor that the transcription process is performed accurately. This Quality Assurance process was revised on 7/1/2013 per recommendation of the Quality Assurance Committee (DON, ADON, Administrator, ANC). DON is submitting all reviews to the Quality Assurance Committee (DON, ADON, Administrator, ANC) weekly for review to ensure effectiveness of the allegation of compliance.
- The Director of Nursing will make a monthly report of the audits to the full Quality Assurance Committee for assessment and recommendation. The audit schedule will be continued until revised by the Quality Assurance Committee. The Administrator will be responsible to assure that the compliance plan is monitored by the Quality Assurance Committee. Administrator will be responsible for monitoring to ensure effectiveness of the compliance plan.
- Also the Quality Assurance Committee (included Medical Director, DON, ADON, Administrator, ANC) met routinely between 7/1/13 and 7/29/13 on the following dates: 7/1, 7/2, 7/3, 7/4, 7/5, 7/8, 7/9, 7/11, 7/12, 7/15, 7/18, 7/22, 7/24, 7/25, and 7/29 to assess reviews and make recommendations. These reviews were assessed by the Quality Assurance Committee (DON, ADON, Administrator, ANC) and will continue to be monitored to ensure effectiveness of the allegation of compliance.



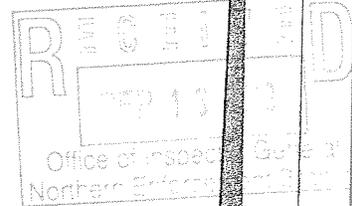
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185388</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2013</b> |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MASONIC HOME OF LOUISVILLE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>240 MASONIC HOME DRIVE<br/>MASONIC HOME, KY 40041</b> |
|---|---|

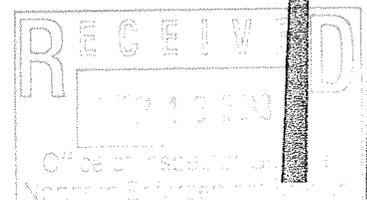
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | (X5) COMPLETION DATE |
|--------------------|---|---------------|--|----------------------|
| F 520              | <p>Continued From page 70</p> <p>Interview with the Interim DON, on 08/01/13 at 3:07 PM, revealed she was not aware of a Medication Error Report. The Interim DON stated someone had brought the form to her attention by reporting the form was documented on the facility policy. The Interim DON stated she was aware there was a problem with incident reports not being completed and reported. The Interim DON stated she was looking to change the policy on reporting medication errors. The Interim DON stated when she was first hired by the facility as a consultant, she came to look at systems and did not identify medication errors as one of the systems that needed to be fixed.</p> <p>Interview with the Medical Director, on 08/01/13 at 4:43 PM, revealed he had attended QA two (2) months ago and five days from the day of the survey exit. The Medical Director stated he attended QA quarterly and he was not aware of the many medication errors identified.</p> <p>Interview with the Administrator, on 08/02/13 at 2:03 PM, revealed the facility had a Quality Assurance (QA) committee that met monthly. The Administrator stated the QA committee should have known about the medication/transcription errors. It was important for these errors to be tracked and trended. The Administrator stated she did look at incident reports in the morning meetings; however, they pertained more to falls. There were no medication errors identified in those meetings. The Administrator stated she would expect the DON to report any concerns.</p> <p>Interview with the Executive Director, on 08/02/13 at 2:03 PM, revealed no medication errors were identified in QA. The Executive Director stated she was not aware of the facility's medication</p> | F 520         | <p>• Masonic Homes VP of Clinical Services will be reviewing QA minutes to assure the effectiveness of the corrective action set forth herein as well as ongoing QA oversight. The Quality Assurance Committee will review required audits and supportive documentation to ensure the effectiveness of the compliance plan and make revisions as necessary on an ongoing basis</p> <p>5. Completed by:</p> | 8-28-2013            |



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

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
|--|---|--|---|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 520  | <p>Continued From page 71<br/>transcription error rate of 12% (based on errors found during record reviews).</p> <p>Review of the Acceptable Allegation of Compliance (AOC) on 08/02/13, revealed the facility took the following immediate actions:</p> <ol style="list-style-type: none"> <li>1. Resident #1 was discharged to the hospital on 04/15/13 and did not return.</li> <li>2. For the facility to identify other residents that might be affected, the quality assurance consultants, under recommendation of the Quality Assurance Committee, completed a chart review that verified care plan were updated, beginning 07/01/13 through 07/31/13.</li> <li>3. In-services were conducted from 07/02/13 through 07/25/13. The in-services included topics of updating the care plan related to medication orders were conducted by the ADON, the Quality Consultant, and the Nursing House Supervisor under the direction of DON. The in-services were attended by all licensed practical nurses and registered nurses.</li> <li>4. The DON, ADON, Administrative Nurse Consultant and other professional consultants were conducting daily reviews of new admissions and daily orders to monitor for accurate processing of new orders and that care plans were updated accordingly.</li> <li>5. The DON was responsible for assuring the daily review process of physician orders and care plan updates as discussed were audited and reported for weekly review by the Quality Assurance Committee.</li> </ol> | F 520  |   |                      |  |



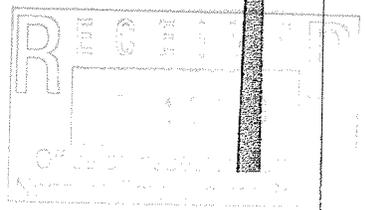
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>185388</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>08/02/2013</b> |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MASONIC HOME OF LOUISVILLE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>240 MASONIC HOME DRIVE<br/>MASONIC HOME, KY 40041</b> |
|---|---|

| (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 520              | <p>Continued From page 72</p> <p>The State Survey Agency validated the AOC on 08/02/13 prior to exit as follows:</p> <ol style="list-style-type: none"> <li>Record review revealed Resident #1 had been discharged on 04/15/13 and not scheduled to return.</li> <li>Record review revealed chart audits were completed on 07/01/13 through 07/31/13 to ensure nursing care plans for residents were up to date. Interview with the DON, on 07/24/13 at 12:21 PM, revealed she reviewed the admission and readmission's orders daily to include physician orders and medication administration records. Interview with the interim DON (Consultant), on 07/26/13 at 12:30 PM, revealed she had completed all chart audits from 07/01/13 to 07/31/13 by looking at physician orders and medication administration records.</li> <li>Record review revealed an in-service was provided by ADON and Quality Consultant on 07/02/13 through 07/25/13, by review of the content of the in-service and review of the attendance logs for the in-service revealed all nursing staff attended the inservice. Interviews conducted on 08/02/13 with five (5) Licensed Practical Nurses: LPN #4 at 4:55 PM, LPN #2 at 6:05 PM, LPN #13 at 5:45 PM, LPN #14 at 6:33 PM, LPN #15 at 6:33 PM, two (2) Registered Nurses: RN #5 at 4:50 PM, and RN #4 at 5:57 PM, and three (3) Certified Medication Technicians (CMT)'s; CMT #1 at 11:22 AM, CMT #20 at 5:55 PM, and CMT #21 at 5:50 PM revealed they were educated on standards of practice, transcription process, communication to pharmacy, medication error process, and re-verification of orders in the EMAR system. Interview with LPN #3 at 08/01/13 at 1:37 PM,</li> </ol> | F 520         |   |                      |



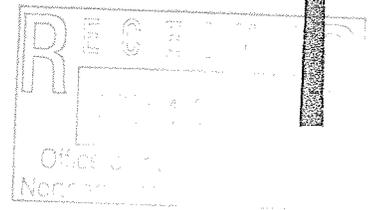
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>08/02/2013 |
|--|--|--|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 520              | <p>Continued From page 73</p> <p>revealed she was educated on the transcription process, standards of practice, communication and ensuring re-verification of orders in the EMAR system. Interview with LPN #16 on 08/02/13 at 6:33 PM, revealed she was also educated on checking for accuracy and making sure not to interpret the orders, but to write the orders exactly as the physician wrote them.</p> <p>4. Record review revealed the Administrative staff conducted daily reviews of new admission and daily orders to monitor to ensure records were accurate. Interview with the DON, on 07/24/13 at 12:21 PM, revealed she reviewed the admission and readmission's orders daily. Interview with the ADON, on 07/24/13 at 10:35 AM, revealed she made copies of discharge summaries, written admission physician order sheet and then compared these documents to the computer to ensure items were correct and matched. Record review revealed the DON submitted all reviews to the Quality Assurance Committee.</p> <p>5. Review of the care plan audit updates and weekly review information given to the QA committee revealed the documents were completed and reviewed by the Committee. Interview with the Interdisciplinary Team (IDT), (Nursing, Activities, Social Services and Dietary), on 08/02/13 at 2:03 PM, revealed the interdisciplinary team met daily to review audits for updates and weekly review of all information obtained through out the week.</p> | F 520         |   |                      |



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

PRINTED: 07/26/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |   |  |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>105388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 02 - SAM SWOPE CARE CENTER<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>07/23/2013 |
|--|--|---|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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, Eight (8) each on the First Floor and Second Floors.</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 07/23/13. Masonic Home of Louisville was found not to be 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</p> | K 000 |  |  |
|-------|---|-------|--|--|

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Ashlee R. Rouse* TITLE: *Executive Director, Administrator* (X6) DATE: *8/29/13*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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.

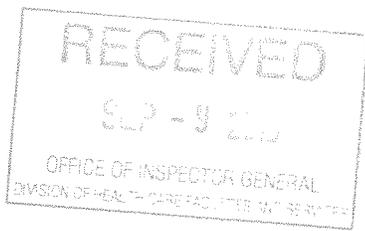
RECEIVED  
SEP - 9 2013  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

RECEIVED  
AUG 29 2013  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 07/26/2013  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 02 - SAM SWOPE CARE CENTER<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br>07/23/2013 |
|--|---|--|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 Fire).  | K 000  |  |  |
| K 147<br>SS=E  | <p>Deficiencies were cited with the highest deficiency identified at E level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by:<br/>Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of the eight (8) smoke compartments on the second floor, approximately forty (40) residents, staff, and visitors. The facility is certified for one-hundred and sixty-seven (167) beds and the census was one-hundred and twenty-one (121) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 07/23/13 between 11:12 AM and 3:05 PM with the Director of Maintenance and the Assistant Director of Maintenance revealed, at 11:12 AM, the Therapy Department had two (2) hydrocollators (medical equipment containing water) plugged into a standard, duplex electrical outlet, instead of a ground fault circuit interrupter (GFCI) as required in wet areas. Observation at 2:50 PM revealed the Resident in Room 276 had a radio and a telephone both plugged into an extension cord. Observation at 2:57 PM revealed the Resident in Room 284 had a free-standing lamp plugged into an extension</p> | K 147  | <p>1. No resident was identified. Duplex plug for hydrocollator equipment in therapy department was replaced with a ground fault interruption (GFI) plug on 7/23/2013. Extension cord in use in resident rooms 276, 284, and 271 were removed on 7/23/2013.</p> <p>2. Maintenance conducted 100% audit of all rooms to ensure that no extension cords or power strips were in use with high draw equipment and that GFI receptacles were used with any appropriate equipment.</p> <p>3. The facility has initiated the following corrective measure to ensure that deficient practice does not reoccur as follows:</p> <p>a. Facility safety policy for "Electrical Power" was reviewed by administrator and maintenance director to ensure inclusion of restriction of power strips for high draw equipment on 8-22-2013.</p> <p>b. Housekeeping/maintenance staff re-educated by Administrator on revised safety policy 8-23-2013</p> <p>c. Electrical outlets and equipment (MNT-13) revised to include power usage of power strips, extension cords, and GFI receptacles completed by maintenance staff.</p> <p>d. Staff re-educated on safety policy update on 8-14-2013</p> <p>4. QA calendar revised on 8-22-2013 to ensure monthly audit of MNT-13 submitted to QA monthly by maintenance staff.</p> <p>QA committee met and approved plans of correction and policy revision 8-23-2013. The QA committee will review required audits and supportive documentation monthly to ensure the effectiveness of the compliance plan and make revisions as necessary on an ongoing basis.</p> <p>5. Completed by:</p> | 8-28-2013                                    |



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

PRINTED: 07/26/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |   |  |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 02 - SAM SWOPE CARE CENTER<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>07/23/2013 |
|--|--|---|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 147 | <p>Continued From page 2</p> <p>cord. Observation at 3:05 PM revealed the Resident in Room 271 also had a free-standing lamp plugged into an extension cord. Extension cords are prohibited for permanent usage per Code requirements.</p> <p>Interviews, on 07/23/13 between 11:12 AM and 3:05 PM, with the Direct of Maintenance and Assistant Director of Maintenance revealed they were aware the requirements for usage of power strips and extension cords. However, they were not aware the two (2) hydrocculators, located within the Therapy Department, were plugged into a standard duplex electrical outlet. The Maintenance Department typically monitored the misusage of power strips and extension cords in the Resident's Rooms and indicated family members sometimes installed them without their knowledge.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D<br/>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric.<br/>Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to</p> | K 147 |  |  |
|-------|--|-------|--|--|

RECEIVED  
5-7-13  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 07/26/2013  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |   |  |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185388 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 02 - SAM SWOPE CARE CENTER<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>07/23/2013 |
|--|--|---|--|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>MASONIC HOME OF LOUISVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>240 MASONIC HOME DRIVE<br>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 147              | Continued From page 3 approval by the authority having jurisdiction.<br><br>Reference: NFPA 70 (1999 edition)<br><br>400-8<br>(Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:<br>(1) As a substitute for the fixed wiring of a structure<br>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors<br>(3) Where run through doorways, windows, or similar openings<br>(4) Where attached to building surfaces | K 147         |   |                      |

If continuation sheet Page 4 of 4  
RECEIVED  
SEP - 9 2013  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES