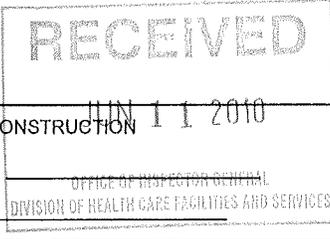


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 06/04/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2010
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NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 240 MASONIC HOME DRIVE MASONIC HOME, KY 40041
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard survey was conducted 05/17/10 through 05/19/10. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. Complaint investigations were initiated on 05/17/10 and concluded on 05/19/10 investigating KY00014709 and KY00014725. KY00014709 and KY00014725 were unsubstantiated with no deficiencies cited.	F 000	This plan of correction is being submitted in compliance with specific regulatory compliance. Neither it's completion nor content is to be construed as an admission by the provider of the validity of any findings or citations contained herein.	
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to utilize a therapeutic meal plan to identify the correct scoop sizes for residents receiving pureed diets. The findings include: Observation of the tray line conducted by the Dining Services Assistant in the main kitchen on 05/18/10 at 4:45pm revealed that a four ounce scoop was used for pureed American goulash.	F 363	1. Dining Services General Manager immediately checked all scoops being used during the evening meal service. Proper scoops were then utilized. 2. No residents were affected by the cited deficiency. 3. All staff, including dining services staff, were re educated May 24, 28, 29 and 30th about using proper scoop size and where to find the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lori Hers TITLE: Administratrix (X6) DATE: 6/10/2010

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.

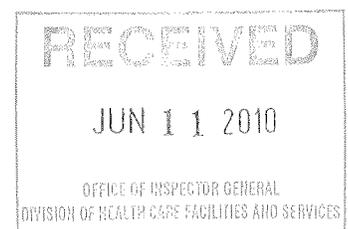
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F 363	<p>Continued From page 1</p> <p>Record review of the therapeutic meal plan revealed that the pureed American goulash serving size should be a six ounce serving size.</p> <p>Interview with the Dining Services Assistant on 05/18/10 at 4:50pm revealed that she was unaware of what serving size to serve for the pureed American goulash. When asked what spoon size was currently being used in the pureed meals, the Dining Services Assistant stated that she was unaware. Interview at 5:52pm revealed the Dining Services Assistant was unaware that the scoop sizes were on the therapeutic meal plan and that the therapeutic meal plan was not looked at that day. She further stated that she always uses four or six ounce scoops when scooping pureed foods and that it is her responsibility to make sure the correct serving sizes are given.</p> <p>Interview with the Dietary Manager on 05/18/10 at 10:57am revealed that he was unaware that staff did not use the therapeutic menu for accurate scoop sizes for pureed meals. The Dietary Manager further stated that if residents do not receive proper portions of food, weight loss may occur.</p>	F 363	<p>information regarding correct scoop size. All new employees will be educated on proper scoop size and where to find this information during their department orientation.</p> <p>4. Supervisor will check before each meal that correct scoops are being utilized and will document on the show time sheet. Dining Services Manager will audit weekly and report findings to Quality Assurance who will determine time of discontinuance when acceptable.</p>	
F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p>	F 371	<p>5. Compliance Date: May 30, 2010</p> <p>1. All facial hair was covered when pointed out as an issue. 2. No residents were affected by the cited</p>	



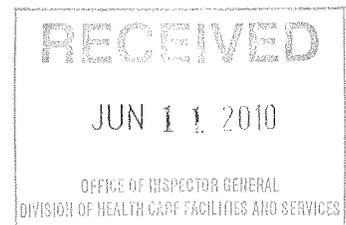
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F 371	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide facial coverings to three male employees. Tray line on 05/18/10 revealed three (3) male employees with facial hair working around food and no knowledge that facial hair coverings were required.</p> <p>The findings include:</p> <p>Observation of the Executive Chef on 05/18/10 at 4:15pm revealed that he was standing above food, cooking a grill cheese sandwich, with an uncovered facial beard. Observation of the Evening Cook on 05/18/10 at 4:15pm revealed he was walking around the kitchen with no covering over the facial beard. Observation of the Dietary Manager on 05/18/10 at 5:45pm revealed that he was walking around food areas with no facial covering.</p> <p>Interview with the Dietary Manager on 05/19/10 at 10:57am revealed he was not aware a mustache and goatee needed to be covered while in the kitchen area. The Dietary Manager revealed that hair retains bacteria and follicles that can fall out. If the hair falls onto food it can contaminate the food. He stated that he has worked with the facility for four years and has never been told that facial hair should be covered.</p> <p>Interview with the Executive Chef on 05/18/10 at 6:00pm revealed that no male staff has ever used hair netting to cover facial hairs while working in the kitchen areas. He stated that hair netting</p>	F 371	<p>deficiency.</p> <p>3. Dining Services policy was revised to read "All staff will be free of facial hair or wear beard covering at all times while in preparation of food." All staff, including dining services, were educated on the new policy on May 24, 28, 29 and 30. All new employees will be orientated to the policy during department orientation. Supervisor will monitor facial hair coverings and ensure in place and document on show time sheet each meal.</p> <p>4. Dining Services General Manager will conduct a weekly audit of the department to ensure proper adherence to our facial hair policy. Findings of the audit will be communicated</p>	



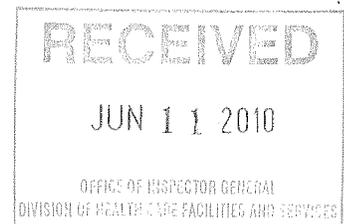
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F 371	Continued From page 3 should be used and that loose particles from the hair can fall into the food and cause contamination to the food. Interview with the Evening Cook on 05/18/10 at 6:05pm revealed that he was oriented to keep facial hair neat and that was an acceptable practice, but concluded that hair may fall into food if facial hair is not covered.	F 371	at the quality assurance meeting and continue until the QA team determines discontinuance is acceptable.	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe functional, sanitary, and comfortable environment for residents, staff, and the public. Numerous items were stored in the stairwell adjoining two buildings in the area of the main dining room and activities room utilized by residents. Items were stored under the stairway and in an adjoining hallway on both sides of the hallway leading to an exit and partially blocking the exit door. The upper level of the stairwell contained additional items stored. The findings include: Observation of the stairwell on May 18, 2010 at 8:35am revealed the following items: - Four mattresses sitting on the floor leaning	F 465	5. Compliance date: May 30, 2010 1. All items in the stairwell were removed. 2. No residents were affected by the cited deficiency. 3. All staff, including dining services staff, were educated May 28, 29 and 30. All new staff will be educated during new employee general orientation. 4. The Director of Environmental Services will make rounds twice weekly to all stairwells to ensure they are clear of any materials. Findings	



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F 465	<p>Continued From page 4 against the wall under the staircase.</p> <ul style="list-style-type: none"> - A box spring leaning against two chairs covered with a gold flowered quilted bedspread. - One housekeeping cart, one cart with six boxes, two metal carts, two large linen carts and two dollies for transporting. - One vacuum cleaner and one large grey trash cart with two trash bags inside. - Two metal bed frames propped against the outside wall. - One motorized buffer, one gallon of high interior latex paint, six florescent light bulbs propped in the corner, two rolling blue and wood trimmed chairs, and three red and gold chairs. - A metal rack (5 feet wide) at eye level, two televisions, eight framed pictures, fourteen pieces of wooden furniture (desks and dressers), an electric organ, and a Genie personal lift. - Two cans of cover-up sealing ceiling paint and two boxes of furnace filters partially occluding the exit door to the outside. - On the upper landing of the stairwell are thirteen plastic chairs, one broken wooden over the bed table, and two bulletin boards. <p>Interview with the Maintenance Supervisor on May 18, 2010 at 2:55pm, revealed he agreed the items stored under and above the stairwell were in violation of fire safety codes and that the items would be removed.</p> <p>Interview with the Director of Nursing (DON) on May 18, 2010 at 2:55pm, revealed many of the items stored in the stairwell were for the new facility (mattresses, box springs, quilted bedspreads, some furniture items). The DON, also acknowledge this was not an appropriate storage area and the items would be moved.</p>	F 465	<p>will be shared at the monthly quality assurance meeting. These rounds will continue until decision is made to discontinue.</p> <p>5. Compliance Date: May 30, 2010</p>	



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K 000	INITIAL COMMENTS	K 000		
K 046 SS=D	<p>A Life Safety Code Survey was initiated and concluded on 06/01/10 for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>Deficiencies were cited with the highest deficiency identified at a "D".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all exterior exits contained emergency lighting as required by NFPA standards.</p> <p>The findings include:</p> <p>Observation during the Life Safety Code survey on 06/01/10, at 2:47pm, with Maintenance Staff, revealed no light fixture at the outside of the Butterfly Landing corridor.</p> <p>Interview with Maintenance Staff on 06/01/10, at 2:47pm revealed he was unaware of the requirement for the outside of the exit. Maintenance Staff stated he would have the problem fixed.</p>	K 046	<p>This plan of correction is being submitted in compliance with specific regulatory compliance. Neither it's completion nor content is to be construed as an admission by the provider of the validity of any findings or citations contained herein.</p> <ol style="list-style-type: none"> 1. Light fixture placed on the outside exit on June 2, 2010. 2. No residents were affected by the cited deficiency. 3. All other exit doors checked on June 2, 2010 to ensure proper light fixtures were in place. All in place and functioning. Maintenance staff will check exterior lights monthly to ensure proper operation and document preventative maintenance. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *hosi Hers* TITLE *Administrator* (X6) DATE *6/10/10*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JUN 11 2010
OFFICE OF INSPECTION
DIVISION OF HEALTH SERVICES

DR

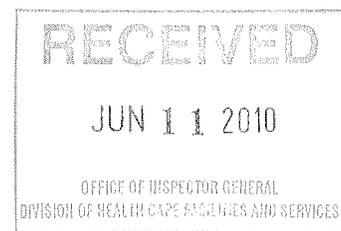
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K 046	Continued From page 1 Reference: NFPA 101 (2000 Edition). 7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 42 (2) Underground and windowless structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed egress locks (5) The stair shaft and vestibule of smokeproof enclosures, which shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment and used for the stair shaft and vestibule emergency lighting power supply For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way.	K 046	4. Director of Maintenance or designee will report monthly preventative maintenance to quality assurance team until decision is made to discontinue. 5. Compliance Date: June 2, 2010	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all exterior exits contained	K 147	1. Light fixture placed on the outside exit on June 2, 2010. 2. No residents were affected by the cited deficiency. 3. All other exit doors checked on June 2, 2010 to ensure proper light	



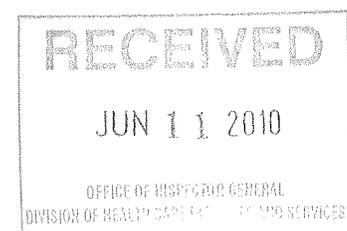
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K 147	<p>Continued From page 2 emergency lighting serviced by the emergency generator as required by NFPA standards.</p> <p>The findings include:</p> <p>Observation during the Life Safety Code survey on 06/01/10, at 2:47pm, with Maintenance Staff, revealed no light fixture at the outside of the Butterfly Landing corridor.</p> <p>Interview with Maintenance Staff on 06/01/10, at 2:47pm revealed that he was unaware of the requirement for the outside of the exit. Maintenance Staff stated that he would have the problem fixed.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following:</p> <ol style="list-style-type: none"> (1) Buildings or structures where required in Chapters 11 through 42 (2) Underground and windowless structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed egress locks (5) The stair shaft and vestibule of smokeproof enclosures, which shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment and used for the stair shaft and vestibule emergency lighting power supply 	K 147	<p>fixtures were in place. All in place and functioning. Maintenance staff will check exterior lights monthly to ensure proper operation and document preventative maintenance.</p> <ol style="list-style-type: none"> 4. Director of Maintenance or designee will report monthly preventative maintenance to quality assurance team until decision is made to discontinue. 5. Compliance Date: June 2, 2010 	



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K 147	Continued From page 3 For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way.	K 147		

