

**RECEIVED**  
No 1919  
JUL 21 2011  
OFFICE OF INSPECTOR GENERAL

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FORM APPROVED  
OMB NO. 0938-0391

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

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  06/23/2011
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NAME OF PROVIDER OR SUPPLIER  MASONIC HOME OF LOUISVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 240 MASONIC HOME DRIVE MASONIC HOME, KY 40041
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F 000	INITIAL COMMENTS  A standard health survey was conducted through June 21-23, 2011 and a Life Safety Code survey was conducted on 06/21/11. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.  F 248 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, clinical record, activity calendars, and activity participation logs, it was determined the facility failed to provide an ongoing activity program in accordance with residents' interest that would enhance the resident's quality of life for three (3) of six (6) neighborhood homes. (Marsh, Walters, and Dialysis) The Dialysis House failed to conduct planned activities called 'Move n Grove' on 06/22/11 and 06/23/11 as scheduled. The Marsh House failed to conduct planned activities as scheduled on 06/21/11, 06/22/11, and 06/23/11. The Walters House failed to conduct planned scheduled activities according to the calendar. In addition, there was no evidence all residents were offered activities of interest and documentation of activity participation was not always complete. During the	F 000	<i>This plan of correction is being submitted in compliance with specific regulatory compliance. Neither its completion nor content is to be construed as an admission by the provider of the validity of any findings or citations contained herein.</i>  F 248	
F 248 SS=E	1) Activities are being conducted as planned per the calendar. All residents have received a monthly household calendar. Household staff are informing and offering assistance to all residents to any activity of interest. All residents now have an activity tracking log to ensure documentation of participation. 2) No other residents were affected by the cited deficiency. 3) Walters, Marsh and Dialysis Household Coordinators along with caregivers and homemakers were educated on providing an ongoing program of activities designed to meet the interests and physical, mental, and psychosocial well-being of each resident. In addition, the Walters, Marsh and Dialysis Household coordinators received additional training to ensure activities meet the interests and needs of each resident. Each resident room has an activity calendar posted at an appropriate height (standing or wheelchair). Each	F 248		

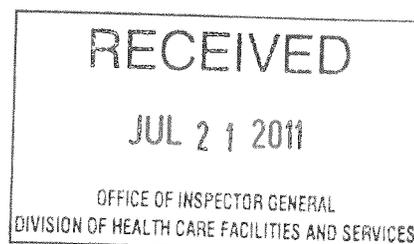
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Walters</i>	TITLE <i>X Executive Director X</i>	(X6) DATE <i>7/21/11</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 248	<p>Continued From page 1</p> <p>Group Interview, residents stated they were unaware of when specific activities of interest were being held; therefore, they did not attend for 3 residents (#18, 25 and 26) of the 26 sampled residents.</p> <p>The findings include:</p> <p>The facility stated there were no activity policies.</p> <p>1. Observation at the Dialysis House, on 06/21/11 at 9:00am, revealed an 8 x 11 activity calendar for the month of June 2011 taped to the front of the refrigerator in the kitchen. The calendar was placed at the height of a standing person's eyes. It was noted that most of the residents living at the Dialysis House were mobile using wheelchairs. In addition, there was only a few feet between the refrigerator and the kitchen counter limiting the space for a wheelchair to approach the calendar.</p> <p>Observation of the Dialysis House, on 06/22/11 at 10:30am and on 06/23/11 at 10:30am, revealed no activities were in progress. The activity calendar revealed 'Move-n-Grove' was to occur on both mornings. There was no evidence of any activity occurring during that time frame.</p> <p>Interview with Resident #6, on 06/21/11 at 3:00pm, revealed most of the activities were not worth going to; however she did attend some activities.</p> <p>Review of the Independent Activity Tracking Log for Resident #6 on 06/22/11 revealed the log was completed through 06/25/11.</p>	F 248	<p>household now has a calendar posted in the common area for residents, staff or visitors to view. The households now have a life enrichment communication binder that informs the household staff what the activity is and where to obtain supplies.</p> <p>4) ) Activity Director will train Chaplain and activity assistant on the audit form. Activity Director or Chaplain, or activity assistant will audit a household activity for all six households, 5x weekly for 4 weeks. Findings of the audit will be communicated at the quality assurance meeting and continue until the Quality Assurance team determines discontinuance is acceptable. Activity Director or Sally's Garden household coordinator, who is a certified activity director, will audit the daily activity logs and review activity calendars monthly. Findings of the audit will be communicated to the Quality Assurance team.</p> <p>5) Compliance Date: 7/23/2011</p>



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F 248	<p>Continued From page 2</p> <p>Interview with the Certified Nurse Aide functioning as Care Giver #12, on 06/23/11 at 12:45pm, revealed she also functioned as the Activity Person. She stated she had received some training; however, was not certified in activities. She indicated she had no experience in managing an activity program. She stated the facility Activity Director was her mentor; however, she had not received actual assistance with any activities. She stated she had difficulty thinking up things to do that would interest the residents. She could not give an explanation for why activities planned on 06/22/11 and 06/23/11 were not completed as schedule.</p> <p>Interview with the Dialysis House Coordinator, on 06/23/11 at 2:20pm, revealed he had never developed an activity calendar or been responsible to supervise the activity staff until June 2011. He stated he did not know why the scheduled activities on the calendar were not completed as planned.</p> <p>Interview with the facility Activity Director, on 06/23/11 at 3:10pm, revealed she provided training to staff on activities in October 2010. She stated she provided training for the Dialysis House Coordinator on 06/08/11. She indicated her role was as a mentor for each House Coordinator and had no supervisory role. She stated she audited one house per month and reported her recommendations to the Administrator.</p> <p>2. On 06/21/11 at 3:00pm, a Group interview was conducted with ten (10) residents from the Judy House, Campbell House, Walters House, Dialysis House, and the Owen House. When asked about the activities provided by the facility, several</p>	F 248	

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F 248	<p>Continued From page 3</p> <p>residents voiced they did not know what activities was offered and when or where the scheduled activities were to be held. Resident # 25 and # 26 stated they had recently missed a music activity that both of the residents would have liked to attend. The residents stated they did not know about the music activity until another resident living in the neighborhood told them about it. This was after the completion of the music activity. Resident #25 strongly voiced she/he would have loved to attend the music activity. The resident indicated there was no activity calendar on the Walters' neighborhood. An unsampled resident from the Owen House stated activities were not being offered as stated on the calendar. In addition, the resident stated the house staff was so busy they did not have time to assist the residents to the planned activities off the neighborhood.</p> <p>Observation of the Walters House on 03/21/11 during the initial tour (9:00am) revealed no activity calendar posted in the neighborhood.</p> <p>Observation of the Walters House on 03/22/11 at approximately 11:30am revealed activity calendars had been placed on the table outside the activity room. (Across from the sitting area with the fireplace). Interview with Resident #25 on 06/22/11 at 11:35am revealed the resident had asked the House Coordinator about the activity calendar after the Group meeting on 06/21/11.</p> <p>During the Group meeting on 06/21/11, Resident #25 and #26 were asked if they had participated in the Milkshakes/cards activity scheduled at 2:00pm prior to the Group meeting. Both residents stated they did not know about the activity, no staff had asked them to attend, and no</p>	F 248	

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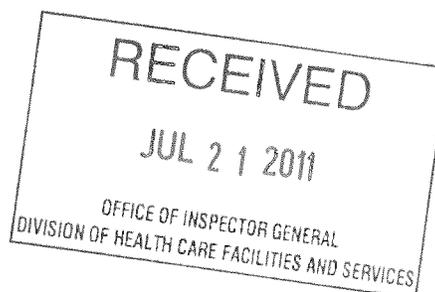
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F 248	Continued From page 4 activity calendar was provided. In addition, one resident stated they loved to play Bingo. Family Bingo was listed on the activity calendar for 06/21/11 at 6:30pm in the multipurpose room. However, staff informed the surveyor that was an error on the calendar, the Family Bingo activity would be held on 06/27/11. The residents in attendance of the Group meeting did not know that was when the Bingo was scheduled.  Review of Resident #18's clinical record revealed the facility admitted the resident on 05/19/11 for short-term rehab services. The facility completed the admission MDS (minimum data set) assessment on 05/27/11 where the resident's preferences for customary routine and activities included: books, newspaper, and magazines to read, listen to music, pets, news, do things with groups of people, and fresh air when weather is good. The resident indicated this was very important. Review of the activity care plan for Resident #18 revealed the resident enjoyed group activities such as Bingo, Television, comes out for meals for socialization and stimulation. The approaches were: offer schedule of activities for resident to select choices, give resident verbal reminders of activity and assist resident in planning leisure-time activity.  Observation of Resident #18, on 06/23/11 at 10:23am, revealed the resident sitting in a wheelchair in the activity room on the Walters' House. The resident was working a puzzle.  Interview with Resident #18 at the time of the above observation revealed the resident likes doing activities and especially liked Bingo. The resident revealed she/he played Bingo weekly in	F 248		

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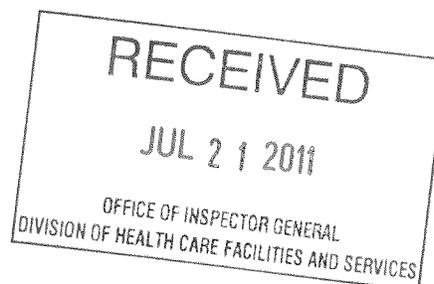
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F 248	Continued From page 5 the Independent Living Facility and missed playing Bingo here. The resident stated reading the newspaper daily was a routine prior to admission to the facility but the newspaper was hardly available on the neighborhood. In addition, the resident did not know when group activities were offered to decide to attend or not. The resident revealed working puzzles and therapy were the only activities the resident was involved in. The resident had not been off the Walters Home for any activity.  Interview with the House Coordinator for Walters House, on 06/23/11 at 2:40pm, revealed all House Coordinators were responsible for activities for that house. She stated each resident received an activity calendar at the beginning of each month and an activity calendar was placed on the table of the sitting area. She acknowledged the activity calendar was not on the table on 06/21/11. The House Coordinator stated since most residents in the neighborhood were here for rehab and were considered short-stay, they did not participate in group activities. She acknowledged Bingo was not offered in this neighborhood. She indicated most residents preferred isolated activities. However, she stated she had not documented which activities residents had attended and does not keep an activity participation log. She stated Resident #18 had not been provided with any music.  Review of the Walters' activity calendar for June 2011 revealed most activities are offered off the neighborhood in the Pillars (personal care unit that is located some distance from the Walters House). Observation of the arts and crafts	F 248		



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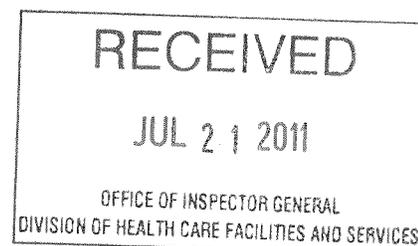
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F 248	Continued From page 6 activity, on 06/23/11 at 10:30am, (In the central craft room located off all units) revealed two (2) residents attended (from the Judy House). Interview with staff who conducted the activity revealed there was a problem of staff getting the residents to the activity.	F 248		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review it was determined the facility failed to ensure care plans were reviewed and revised by a team of qualified persons after each assessment for 3 (three) of 26 (twenty-six)	F 280	F 280 1) Resident #11, 12 and 20 had a care plan meeting. 2) All other residents RAI's in the Judy House were audited to ensure a care plan meetings were performed. 3) MDS coordinator will provide Executive Director with Judy House residents ARD dates. The Judy Household Coordinator will provide the Executive Director a copy of the care plan calendar and care plan sign in sheets upon completion of each care plan to ensure care plans are being held periodically upon completion of each assessment for eight weeks. 4) Results of the Judy House care plan meeting audit performed by the Executive Director will be presented monthly to the quality assurance team until decision is made to discontinue. 5) Compliance Date: 7/23/2011	



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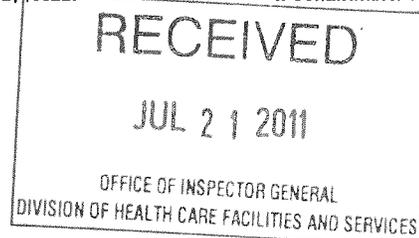
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F 280	Continued From page 7 sampled residents (Residents #11, #12 and #20).  The findings include:  Policy review of Resident Care Plans, that was undated, revealed Resident's needs, conditions and abilities will be reflected in the care plan and would be reviewed and revised periodically after assessments by qualified staff, as the resident's condition warrants at a minimum of twice a year.  Record review for Resident #11 revealed the last care plan meeting was held on 01/14/11. An annual Resident Assessment Instrument (RAI) assessment was completed on 04/01/11, there was no evidence of a follow up care plan meeting.  Record review for Resident #12 revealed the last care plan meeting was held on 01/21/11. An annual RAI was completed on 04/08/11, there was no evidence of a follow up care plan meeting.  Record review for Resident #20 revealed the last care plan meeting was held on 01/28/11. A quarterly RAI was completed on 04/18/11, there was no evidence of a follow up care plan meeting.  Interview with the Nurse Leader Judy House, on 06/22/11 at 11:45am, revealed the facility policy is for all care plans to be updated a minimum of two times per year.  Interview with MDS Coordinator, on 06/23/11 at 2:45pm, revealed care plans should be	F 280		



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F 280	Continued From page 8 completed quarterly after each RAI assessment. She stated the care plan meeting is made up of the resident and resident's family (if they want to attend), and all team members involved in the resident's care such as nurse, dietary, therapy, etc. The MDS Coordinator revealed the care plan meeting should be held within seven days after the quarterly assessment and documented on the care plan meeting sheet located in the chart, in front of the care plan. This sheet indicates who attended the care plan meeting, the date, the assessment, what was discussed and the goals. She expressed surprise the facility policy stated care plan meetings should be held a minimum of two times per year.	F 280			
F 282 SS=D	483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, resident record review, review of the facility Resident Care Plan Policy and review of the Owen House Caregiver Assignment sheet, the facility failed to follow the written Plan of Care for one (1) of twenty-four (24) sampled residents. Heel protectors were not applied to Resident #10, as ordered, while in bed, and assessed at risk for skin breakdown. Furthermore, Resident #10 sustained a fall during a transfer in which a gait belt was not used. The gait belt was care planned under potential for injury, to be used for all assisted transfers.	F 282	F 282 1) Resident #10 heel protectors were discontinued per resident request. Plan of care was updated per physician order. Discipline was given to staff cited in deficiency regarding heel protector and non use of gait belt. 2) Resident #10 was not found to be affected by cited deficiency as evidenced by no skin breakdown or injury. All residents with heel protectors were assessed by DON, ADON and House Nurse Leader to determine compliance per plan of care. 3) Nurses and caregivers were re educated on following resident's written plan of care by 7/23/2011. All households were inventoried for adequate number gait belts.		



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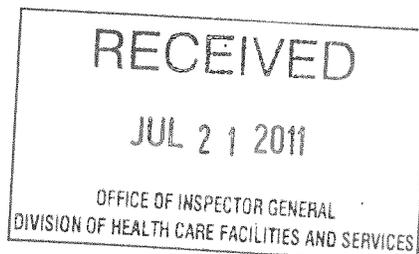
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F 282	<p>Continued From page 9</p> <p>Review of the facility policy on Resident Care Plans revealed resident's needs, conditions and abilities will be reflected in the care plan.</p> <p>Review of the current physician's orders, signed off on 06/02/11, for Resident #10, revealed heel protectors are to be applied to bilateral feet while in bed (7A-7P, 7P-7A).</p> <p>Record review of the Owen House Caregiver Assignment, revealed for Resident #10, heel protectors are to be applied to bilateral feet while in bed.</p> <p>Record review of the Plan of Care for Resident #10 revealed the approach "Treatment and Prevention as ordered" under the care planned problem of potential for skin breakdown. Heel protectors were ordered for prevention.</p> <p>Interview on 06/22/11 at 5:15pm with Certified Medication Technician (CMT) #5 revealed she did not put the heel protectors on Resident #10 when the resident took his/her nap. However, she revealed she did sign the Treatment Administration Record to indicate the heel protectors were on the resident, when, in fact, they were not.</p> <p>Interview on 06/23/11 at 8:20am with Certified Nursing Assistant (CNA) #7 revealed whoever puts the resident to bed would put on the heel protectors.</p> <p>Interview on 06/23/11 at 9:10am with Licensed Practical Nurse (LPN) #1 revealed it is the nurses responsibility to put the physician ordered heel</p>	F 282	<p>4) Nurse leader and Household Coordinator and selected caregivers who are assigned to each house will be educated by Executive Director and Director of Nursing on how to conduct weekly rounds to ensure residents plan of care are being followed. Findings from rounds will be addressed immediately with the house leaders and presented monthly to the quality assurance team until decision is made to discontinue.</p> <p>5) Compliance Date: 7/23/2011</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2011
NAME OF PROVIDER OR SUPPLIER  MASONIC HOME OF LOUISVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 240 MASONIC HOME DRIVE MASONIC HOME, KY 40041	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
F 282	<p>Continued From page 10</p> <p>protectors on the resident. The CNA may remove the heel protectors after checking with the nurse. She stated the nurse is to chart the heel protectors are on the resident while in bed on the Treatment Administration Record (TAR).</p> <p>Interview on 06/23/11 at 8:40am with the Owen House Nurse Leader revealed the CNA's are responsible to put the heel protectors on the resident because they are the ones putting the resident to bed. She further revealed the CMT or the nurse on duty is to make sure the heel protectors are on. She stated if the heel protectors are not used, skin breakdown may occur.</p> <p>Observation on 06/21/11 at 3:17pm of Resident #10 while she was in bed for a nap revealed no heel protectors were on the resident.</p> <p>Observation on 06/22/11 at 2:25pm of resident #10 while she was in bed for a nap revealed no heel protectors were on the resident.</p> <p>Review of the Plan of Care for Resident #10 revealed, under the topic potential for injury, a gait belt is to be used for all assisted transfers.</p> <p>Review of the Owen House Caregiver Assignment for Resident #10 revealed, the resident requires transfer with the assist of two (2).</p> <p>Interview on 06/23/11 at 9:45am with CNA #7 revealed she was transferring Resident #10 by herself, without the use of a gait belt, and the resident sustained a fall on 06/16/11. It was further revealed she had been taught in the use</p>	F 282	



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F 282	Continued From page 11 of the gait belt but chose not to use it. She stated the consequence for not using the gait belt would be the resident could get hurt.  Interview on 06/23/11 at 11:20am with the Owen House Nurse Leader revealed the staff had been in-serviced on the use of the gait belt. She revealed to not use the gait belt had the potential for injury to the resident.  Interview on 06/23/11 at 1:55pm with the Director of Nursing revealed the purpose of the gait belt is to help with safety.	F 282			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on interview and clinical record review it was determined the facility failed to obtain labwork as ordered by the physician and according to the care plan for one (1) of twenty-six (26) sampled residents. Resident #18 had a positive stool culture for C-diff (Clostridium) that required antibiotic treatment. The physician ordered a follow-up stool culture to be obtained three days after completion of the antibiotic medication. However, the facility failed to obtain the stool culture as ordered on 05/31/11. In	F 309	F 309 1) Lab order was discontinued due to no signs and symptoms. 2) All other residents with lab orders were audited to ensure requisition and results were obtained. 3) The lab policy was updated to include placing lab orders on the treatment administration record. Appropriate nursing staff was educated on the policy update. The nurse leaders met with the lab company on 7/8/11 to ensure necessary care and services are obtained. 4) The six nurse leaders will bring their household lab communication binder located in the household charting room to the morning quality assurance meeting. DON or ADON will audit lab binder weekly to ensure necessary care and services are obtained per the plan of care related to labs. Findings from audit will be presented monthly to the quality assurance team until decision is made to discontinue. 5) Compliance Date: 7/23/2011		

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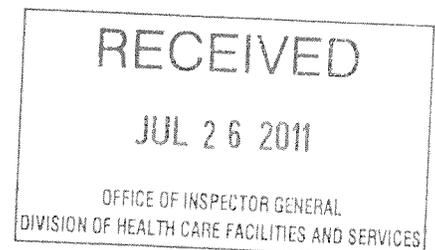
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F 309	Continued From page 12 addition, the nurse practitioner reordered the stool culture on 06/20/11 and there was no evidence the stool culture was obtained as ordered.  The findings include:  Review of the Lab policy revised on 04/20/11 revealed when a lab is ordered by the physician or nurse practitioner. The staff nurse will complete a lab requisition with appropriate date and correct lab to be obtained marked. the lab requisition slip will be placed in the appropriate date file in the lab box.  Review of Resident #18's bowel care plan with a revision date of 05/27/11 revealed labs to be obtained as ordered. Review of the resident's clinical record revealed a positive stool culture for C-diff report from the laboratory on 05/31/11. The physician was notified and orders received for an antibiotic (Flagyl 500mg three times a day for seven days) on 05/31/11. In addition, the physician ordered contact isolation and a follow-up stool culture to be obtained three (3) days after the Flagyl was completed. (June 10, 2011) On 06/20/11, the nurse practitioner requested the 06/10/11 C-diff stool results and "if not done, please collect ASAP!" Continued review of the clinical record revealed no documented evidence the stool culture was obtained.  On 06/23/11 at 3:30pm, interview with the staff nurse on Walters' House revealed she had looked for the follow-up stool test and could not find any evidence the lab was obtained as ordered. She stated she called the laboratory service and they had no record the follow-up stool	F 309			

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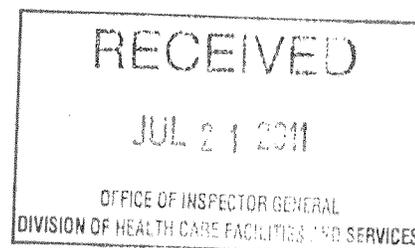
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185368	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  06/23/2011
NAME OF PROVIDER OR SUPPLIER  MASONIC HOME OF LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 240 MASONIC HOME DRIVE MASONIC HOME, KY 40041		
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F 309	Continued From page 13 culture was obtained. The nurse revealed she had not been working this house when the stool culture was ordered and does not know why it was not obtained.  Interview with the Walters' House Coordinator, on 06/23/11 at 2:40pm, revealed she did not know why the lab was missed. She revealed the facility system for obtaining labwork was the nurse who took the physician order would complete the lab requisition slip for the date the lab was to be done. The laboratory service would pick up the stool specimen and take it to the laboratory for testing. The results are then faxed to the facility.	F 309			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on resident record review, facility policies on Falls and Injuries and Fall/Injury Management, Post-Fall Assessment Roster, Resident Incident Report and Post-Incident Actions, Owen House Caregiver Assignment Sheet and interview, it was determined the facility failed to provide one (1) of twenty-six (26) sampled residents, Resident #10, with adequate supervision and an assistive device to prevent an accident. Resident #10 sustained a fall during a one person transfer,	F 323	F 323 1) Discipline was given to staff member cited in deficiency for failure to provide adequate supervision and use of assistive device for resident #10. Discipline was also given to nurse who failed to investigate causal factors of the fall for resident #10. Resident # 10 was evaluated by Therapy and ARNP confirmed fall was related to weakness and recommended discontinuing two person assist. Resident ok for one person assist and gait belt as needed during transfers. Care plan updated per Therapy and ARNP recommendations. 2) No other residents were affected by the cited deficiency as evidenced by the DON re investigating all falls during transfers for last thirty days. All appropriate assistive devices were		



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F 309	Continued From page 13 culture was obtained. The nurse revealed she had not been working this house when the stool culture was ordered and does not know why it was not obtained.  Interview with the Walters' House Coordinator, on 06/23/11 at 2:40pm, revealed she did not know why the lab was missed. She revealed the facility system for obtaining labwork was the nurse who took the physician order would complete the lab requisition slip for the date the lab was to be done. The laboratory service would pick up the stool specimen and take it to the laboratory for testing. The results are then faxed to the facility.  F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES SS=D The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on resident record review, facility policies on Falls and Injuries and Fall/Injury Management, Post-Fall Assessment Roster, Resident Incident Report and Post-Incident Actions, Owen House Caregiver Assignment Sheet and Interview, it was determined the facility failed to provide one (1) of twenty-six (26) sampled residents, Resident #10, with adequate supervision and an assistive device to prevent an accident. Resident #10 sustained a fall during a one person transfer,	F 309	F 323 1) Discipline was given to staff member cited in deficiency for failure to provide adequate supervision and use of assistive device for resident #10. Discipline was also given to nurse who failed to investigate causal factors of the fall for resident #10. 2) No other residents were affected by the cited deficiency. 3) Nurses, selected caregivers from each house and household coordinators were re educated on adequate supervision and using assistive devices to prevent accidents by 7/23/2011. Nurses were re educated on investigating causal factors of a fall by 7/23/2011. All households were inventoried for adequate number of assistive devices. Incident report was updated to reflect assessment of assistive devices used

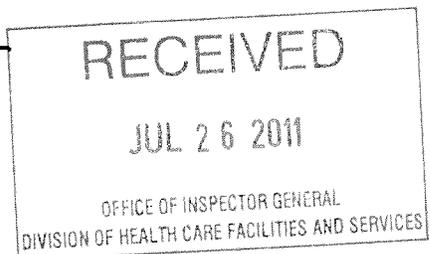


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F 323	<p>Continued From page 14</p> <p>after the facility assessed the resident as a two person transfer, and care planned for the use of an assistive device, a gait belt, which was not used. The facility further failed to investigate the causal factors of the fall to prevent a reoccurrence.</p> <p>The findings include:</p> <p>Review of the facility's policy on Falls and Injuries revealed the Interdisciplinary Team (IDT) implements appropriate interventions to reduce the risk of falls or injuries. A gait belt had been identified by the facility for safety during transfers, however, this was not used during the transfer of Resident #10, subsequently a fall occurred.</p> <p>Review of the facility's policy on Fall/Injury Management revealed the findings following a fall would be discussed with the resident and family for inclusion in the Interdisciplinary Care Plan meeting. However, the facility could not provide evidence of an investigation identifying the causal factors of the fall.</p> <p>Review of the facility's Post-Fall Assessment Roster, dated 06/16/11, revealed no causal factor was identified for the fall of Resident #10. It further revealed in the assessment that no staff was involved during the incident. Certified Nursing Assistant #7 was involved and reported the fall.</p> <p>Review of the facility's Resident Incident Report, dated 06/16/11, revealed a CNA was transferring Resident #10 when the fall occurred. There was no inclusion of safety devices in the report, either their use or the lack of.</p>	F 323	<p>documented and in place at time of fall.</p> <p>3) Nurses, selected caregivers from each house and household coordinators were re educated on adequate supervision and using assistive devices to prevent accidents. by 7/23/2011. Nurses were re educated on investigating causal factors of a fall by 7/23/2011. All households were inventoried for adequate number of assistive devices.</p> <p>Incident report was updated to reflect assessment of assistive devices used during transfers. Director of Nursing educated the Household Coordinators who then educated the nurse leader and caregivers who completed rounds every two hours for two weeks checking to ensure assistive devices and adequate supervision was in place for resident transfers.</p> <p>4) Rounds by household coordinator, nurse leader and selected caregivers from each house will continue weekly and findings will be presented monthly to the quality assurance team until decision is made to discontinue. Weekly falls meeting will be conducted with nurse leaders and a fall mentor will be designated to help supervise and ensure proper investigation of causal factors of a fall.</p> <p>5) Compliance Date: 7/23/2011</p>

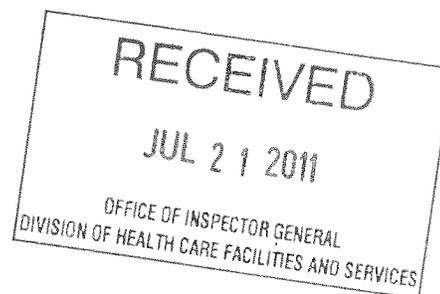
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F 323	<p>Continued From page 14</p> <p>after the facility assessed the resident as a two person transfer, and care planned for the use of an assistive device, a gait belt, which was not used. The facility further failed to investigate the causal factors of the fall to prevent a reoccurrence.</p> <p>The findings include:</p> <p>Review of the facility's policy on Falls and Injuries revealed the Interdisciplinary Team (IDT) implements appropriate interventions to reduce the risk of falls or injuries. A gait belt had been identified by the facility for safety during transfers, however, this was not used during the transfer of Resident #10, subsequently a fall occurred.</p> <p>Review of the facility's policy on Fall/Injury Management revealed the findings following a fall would be discussed with the resident and family for inclusion in the Interdisciplinary Care Plan meeting. However, the facility could not provide evidence of an investigation identifying the causal factors of the fall.</p> <p>Review of the facility's Post-Fall Assessment Roster, dated 06/16/11, revealed no causal factor was identified for the fall of Resident #10. It further revealed in the assessment that no staff was involved during the incident. Certified Nursing Assistant #7 was involved and reported the fall.</p> <p>Review of the facility's Resident Incident Report, dated 06/16/11, revealed a GNA was transferring Resident #10 when the fall occurred. There was no inclusion of safety devices in the report, either their use or the lack of.</p>	F 323	<p>during transfers. Director of Nursing educated the Household Coordinators who then educated the nurse leader and caregivers who completed rounds every two hours for two weeks checking to ensure assistive devices and adequate supervision was in place for resident transfers.</p> <p>4) Rounds by household coordinator, nurse leader and selected caregivers from each house will continue weekly and findings will be presented monthly to the quality assurance team until decision is made to discontinue. Weekly falls meeting will be conducted with nurse leaders and a fall mentor will be designated to help supervise and ensure proper investigation of causal factors of a fall.</p> <p>5) Compliance Date: 7/23/2011</p>



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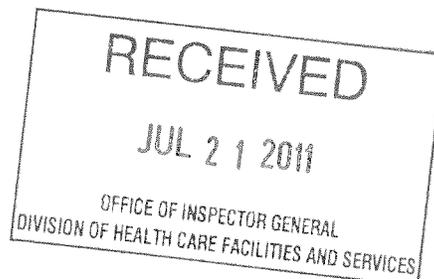
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F 323	<p>Continued From page 15</p> <p>Review of the facility's Post-Incident Actions, dated 06/16/11, revealed the Immediate post-incident action was "Assist x 2 (times two) when transferring resident". This action was identified prior to the fall as an intervention of the care plan.</p> <p>Review of the Owen House Caregiver Assignment sheet, for the date the resident fell and provided by the Nurse Leader of Owen House, where Resident #10 lived, revealed Resident #10 was to be transferred with the assist of two (2) prior to the fall.</p> <p>Review of the Interdisciplinary Care Plan for Resident #10, last reviewed by the facility on 06/05/11, revealed a gait belt was to be used on all assisted transfers.</p> <p>Record review revealed the facility assessed Resident #10 on 04/20/11 using the Minimum Data Set (MDS) as requiring extensive assist upon transfer with the assist of two (2) persons. When Resident #10 fell, only one person was present to transfer.</p> <p>Interview, on 06/23/11 at 9:45am, with CNA #7 revealed she was present when Resident #10 fell on 06/16/11. The resident was being transferred by CNA #7, without the assist of another staff member as instructed on the assignment sheet, and there was no gait belt around Resident #10. CNA #7 revealed failure to use the gait belt could result in a resident getting hurt.</p> <p>Interview, on 06/23/11 at 9:10am, with Licensed Practical Nurse (LPN) #1 revealed when Resident</p>	F 323	

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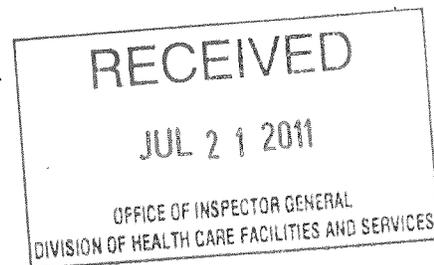
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F 323	Continued From page 16 #10 fell it was reported to her. She stated the resident did not have on a gait belt and that CNA #7 was transferring the resident. However, noted again, the facility Post-Fall Assessment Roster dated 06/16/11 revealed no causal factor was identified for the fall of Resident #10 and no staff was involved during the incident which took place during the transfer.  Interview, on 06/23/11 at 2:55pm, with the Nurse Leader of the Owen House revealed a thorough investigation into a fall would include: where it occurred; how the incident occurred; why, as in why was the CNA alone with no help; and when did the incident occur. It was further revealed, the fall of Resident #10 did not have a thorough investigation. It was also stated, the lack of the gait belt had the potential for injury and should have been investigated.  Interview, on 06/23/11 at 1:55pm, with the Director of Nursing revealed she was not aware a gait belt was not used during the transfer which resulted in the fall of resident #10. A thorough investigation did not take place. If she had known of the CNA's failure to use a gait belt, the CNA would have been educated on its use and purpose, which is to help with safety.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  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	F 371	F 371 1) All unsealed and unlabeled containers of food were disposed of. The glasses, bowls and ladle were re sanitized. Food was removed from the steam table and either disposed or reheated to proper serving temperature.	



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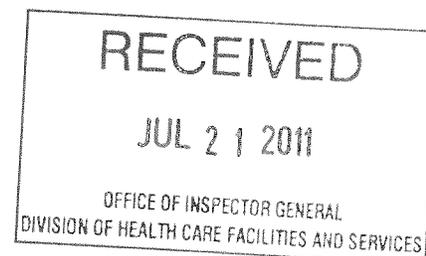
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2011
NAME OF PROVIDER OR SUPPLIER  MASONIC HOME OF LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 240 MASONIC HOME DRIVE MASONIC HOME, KY 40041	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 17  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's temperature log and checklist and facility's policy it was determined the facility failed to reseal and label opened containers of food stored in the freezer and the refrigerator. The Marsh House utilized a fan on the dishes and partially dried glasses were stored in the cabinets and remained wet from the previous meal service. The Campbell House had ten (10) of twenty-four (24) bowls had residual water and residual food particles from the previous meal service. The Campbell House Homemaker touched the entire ladle that was suppose to be used to serve the food. The Campbell House and the Dialysis House failed to ensure food temperatures served from the steam table were safe. Review of the temperature logs identified unsafe food temperature range of 50.8 degrees Fahrenheit (F.) to 132. degrees F. temperature and multiple meals where temperatures were not obtained.  The findings include:  Review of the facility policy for Meal Temperature Record, dated October 2009, revealed accurate temperatures would be taken and recorded using a calibrated thermometer. If hot food temperatures were not greater than or equal to the standards, or cold temperatures are not less than or equal to the standards, respond and correct.	F 371	2) No residents were affected by the cited deficiency as evidenced by no signs or symptoms related to ingestion of food served at unsafe temperatures. 3) Dining Services, Homemakers, Nurse Leaders and Household Coordinators were re educated on storage and labeling of food, proper ways to serve food, proper sanitation, drying and storage of dishes and obtaining and ensuring safe food temperatures. Each household has been provided with 4 additional dish racks to insure proper drying. A new position was implemented to manage the homemaker position. The meal temperature log and checklist was updated to include the safe temperature zones. All new employees, who will be educated by a member of the Dining Services management team, will be educated on how to store, prepare, distribute and serve food under sanitary conditions during their department orientation. 4) Dining Services management team will conduct daily audits checking for storage, preparation, serving and distributing food in a sanitary condition during a meal service for four weeks. Findings of the audit will be communicated at the quality assurance meeting and continue until the Quality Assurance team determines discontinuance is acceptable. 5) Compliance Date: 7/23/2011	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2011
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F 371	<p>Continued From page 18</p> <p>Record review of the Campbell House temperature log and checklist dated 05/30/11 revealed the fried eggs and Canadian bacon temperature was 90 degrees F. at breakfast meal service. The dinner service revealed the vanilla pudding parfait temperature was 70.6 degrees F.. The Campbell House temperature log and checklist dated 05/29/11 revealed the dinner service</p> <p>The Campbell House temperature log and checklist revealed food temperatures were not obtained for dinner on 03/16/11, lunch 03/17/11, 03/18/11, lunch and dinner on 03/21/11, lunch and dinner on 03/22/11, dinner on 03/24/11, dinner on 03/25/11, lunch and dinner on 03/27/11 and 03/28/11, dinner on 03/29/11, and lunch on 03/30/11. The Campbell House temperature log and checklist dated back to 03/01/11 through 06/22/11 revealed the milk, juice and dessert temperatures were not obtained.</p> <p>Observation of the Dialysis House lunch meal, on 06/22/11 at 11:25am, revealed broccoli with a steam table temperature of 49 degrees Fahrenheit (F), baked chicken at 50.8 degrees F, and mashed potatoes at 74.6 degrees F. The temperatures were logged and the server began dishing up the food for delivery to residents.</p> <p>Interview with Homemaker #8, on 6/22/11 at 11:45am, revealed she did not know what temperature the food on the steam table should be to ensure hot food was in a safe temperature zone, 135 degrees F or above. She stated she</p>	F 371	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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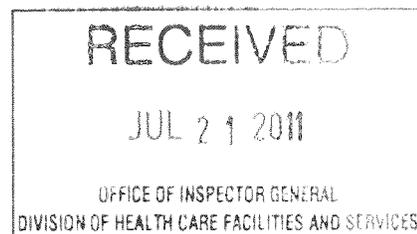
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F 371	<p>Continued From page 19</p> <p>did not communicate the food temperatures to the server. She stated she normally took the temperatures on the steam table and logged them into a book and took no other action. She indicated she did not know if the thermometer was in Farenheit (F) or Celsius (C). She was not able to remember if she had received training on proper/safe food handling including safe food temperatures prior to becoming responsible for dietary duties.</p> <p>Interview with Homemaker #9, on 06/22/11 at 12:15pm, revealed she did not check the steam table temperature log or ask Homemaker #8 what the food temperatures were prior to serving the food off the steam table. In addition, she stated she did not know how the thermometer was set, F or C. After calling the main kitchen, she stated the thermometer was set at F and the food should be at least 165 degree F. She stated the food temperatures were too cold to have been served to residents and the steam table was being used as a functional steam table. After discussion with a dietary staff person from the dietary department, she stated the residents had the right to have food come from the steam table at whatever temperature they requested. She stated she had received some training prior to becoming responsible for dietary duties.</p> <p>Review of the steam table food temperatures log for June 2011 revealed the Dialysis House routinely recorded steam table temperatures for hot food below the safe temperature of 135 degrees F.</p> <p>Interview with the General Manager of the Dietary Department, on 06/23/11 at 1:00am, revealed</p>	F 371	

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FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2011
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F 371	<p>Continued From page 20</p> <p>staff were trained regarding the food danger zone and to obtain temperatures of the hot food on the steam table by using degrees in F. He stated Homemakers #8 and #9 were trained in the certified Food Service Managers course. In addition, he stated there was a lead homemaker whose job included auditing the steam table temperature logs on a weekly basis.</p> <p>Interview with the Lead Homemaker, on 06/23/11 at 1:35pm, revealed she did complete an audit of each House on a weekly basis which included a review of the steam table temperature logs; however, she only reviewed the logs for blanks and did not ensure temperatures were appropriate. She stated she was certified as a Food Service Manager and had received training. She stated the Household Coordinator was responsible to ensure steam table temperatures were safe.</p> <p>Interview with the Household Coordinator, on 06/23/11 at 2:20pm, revealed he was responsible; however, the staff did not indicate a problem with temperatures.</p> <p>Review of the facility's policy for Food and Supply Storage Procedures, dated 07/2010, revealed all food, non-food items and supplies used in food preparation shall be stored in such a manner as to maintain the safety and wholesomeness of the food for human consumption. Cover, label and date unused portions and open packages.</p> <p>Review of the facility's policy for Storage of Pots, Dishes, Flatware, Utensils dated 11/2009,</p>	F 371	



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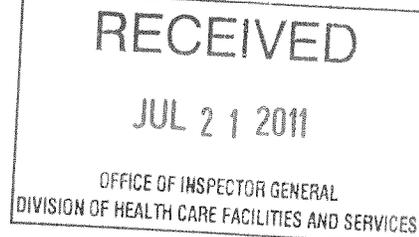
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F 371	<p>Continued From page 21</p> <p>revealed pots, dishes, and flatware are stored in such a way as to prevent contamination by splash, dust, pests, or other means. Air dry all food contact surfaces, including pots, dishes, flatware, and utensils before storage, or store in a self-draining position.</p> <p>Initial tour of the main kitchen on 06/21/11 at 9:05am revealed a five (5) pound bag of high fat cocoa opened with no date, an eleven (11) pound bucket of gold medal chocolate fudge icing opened with no date, a container of beyond liquid butter alternative opened with no date in the dry storage area. Observation of the walk-in freezer revealed a box of frozen breaded chicken patties unwrapped and not dated, and a bag of frozen french fries opened, unsealed, and not dated. Observation of the walk-in cooler revealed a package of tortillas opened with no date, and a thirty-two (32) ounce bottle of ocean spray orange juice opened and not dated.</p> <p>Interview with the Food Service Manager, on 06/23/11 at 4:50pm, revealed weekly audits are completed every Tuesday on the sanitation checklist. The Food Service Manager stated an audit had not been completed for this week. There was a potential risk to the resident with food born illness by not properly storing and dating food items. The audits do need improvement and the current system for monitoring the labeling and storage of food items was not working. He did state responsibility for ensuring food items are stored and labeled appropriately.</p> <p>Observation of the Marsh House Kitchen, on 06/21/11 at 3:05pm, revealed ten (10) large</p>	F 371			

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FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2011
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F 371	Continued From page 22 plastic cups, and three (3) small plastic cups stored wet, upside down in the cabinet.  Observation of the Marsh House Kitchen, on 06/23/11 at 9:55am, revealed wet plastic glasses, turned upside down on counter next to the dish washing sink. The glasses were stacked four (4) high with a fan blowing directly on the glasses. The dish storage cabinet revealed small plastic glasses stored wet and turned upside down.  Interview with Homemaker #7, on 06/23/11 at 10:05am, revealed homemakers are responsible for cleaning the kitchens and washing dishes. She revealed she completed a safe serve course which contained information on kitchen sanitation and being instructed to dry the dishes in the dish racks, however, there was not a sufficient number of racks to dry all the dishes. Homemakers were told to stack the remainder of the glasses upside down on the sink counter to air dry. The facility placed a fan in the kitchen to help dry the dishes and this method had not been working. The homemaker revealed storing dishes wet could lead to bacteria growth, and the fan could spread dust and debris around the kitchen.  Interview with the lead homemaker, on 06/23/11 at 1:40pm, revealed weekly audits are done in each house kitchen, however dishwashing, drying, and storage of the dishes was not included in the audit.  Interview with Homemaker #1, on 6/23/11 at 2:40pm, revealed not being trained on how to wash or dry the dishes used in Marsh House.  Interview with the Food Service Manager, on	F 371		





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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2011  
FORM APPROVED  
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F 441	<p>Continued From page 24</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policies: Hand Washing/Hand Hygiene; Hand Washing/Hand Hygiene Procedure; and Dressing Change, and review of employee training on Sterile Dressing Application, and wound assessment and documentation the facility failed to ensure infection control guidelines were followed during a dressing change for two (2) of twenty-six (26) sampled residents (#7 and #18). In addition, Marsh House guest bathroom, which was observed being utilized by residents, visitors, and staff, did not have soap for handwashing for two (2) consecutive days during the survey.</p> <p>The findings include: Review of the facility's policy for Hand Washing/Hand Hygiene, not dated, revealed Employees must wash their hands using antimicrobial or non-antimicrobial soap and water under the following conditions: when hands are visibly soiled; after contact with blood, body fluids, secretions, mucous membranes or non-intact</p>	F 441	<p>annual check off for dressing application was updated to include changing gloves after removing soiled dressing or hand washing between donning gloves. A checklist was provided to the household detailing the proper steps when cleaning and checking the bathroom. The Marsh household coordinator or designee will monitor the guest bathroom daily for four weeks.</p> <p>4) The updated check off will be used with one nurse every shift for 7 days. Thereafter, the check off will be used with a nurse everyday for 7 days. Finally, the check off will be used with a nurse every week for two weeks and then a nurse every month for three months. Marsh Household Coordinator will report findings to the quality assurance team in the monthly meeting until the Quality Assurance team determines discontinuance is acceptable. Environmental Services mentor will audit all houses guest bathrooms monthly. Findings of the audit will be communicated at the quality assurance meeting.</p> <p>5) Compliance Date: 7/23/2011</p>

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F 441	Continued From page 25 skin; after handling items potentially contaminated with blood, body fluids, or secretions; and before eating and after using the restroom. If hands are not visibly soiled, use an alcohol-based hand rub for all the following conditions: before direct contact with residents, before donning sterile gloves; before handling clean or soiled dressings, gauze pads, etc; after handling used dressings, contaminated equipment; and after removing gloves.  Review of the facility's policy for Hand Washing/Hand Hygiene Procedure, not dated, revealed the purpose of this procedure was to guide proper hand washing and techniques to help prevent transmission of infections. The following equipment and supplies will be necessary when performing the procedure: running water, soap (liquid or bar, anti-microbial or non-antimicrobial) or alcohol based rub containing 60-95% ethanol or isopropanol.  Review of the facility's policy for Dressing Change, not dated, revealed hands should be washed prior to beginning dressing change and gloves should be changed after removing soiled dressing.  1. Observation of the dressing change, on 06/21/11 at 3:40pm, by Licensed Practical Nurse (LPN) #1 revealed LPN#1 removed a saturated dressing with brownish colored drainage with gloved hands. The LPN did not remove soiled gloves after removing the old dressing. While still donning soiled gloves, the LPN picked up the bottle of Dakins solution, saturated the clean dressing, picked up a newly prepared dressing and placed it on the resident's intact abdominal	F 441		

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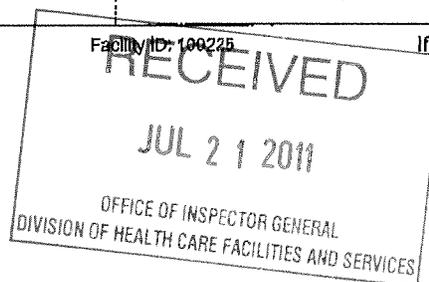
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F 441	<p>Continued From page 26</p> <p>skin. The LPN then dragged the clean dressing across the abdomen and pushed the saturated dressing into the wound. The gloves were then removed and thrown away. The LPN then moved the overbed table close to the Resident, and repositioned the water glass by picking it up by the rim of the glass before ever washing hands. Interview with the LPN on hand hygiene during the dressing change revealed gloves should be changed after removing the old dressing and hands should be washed after completion of dressing changes.</p> <p>Further Interview with LPN#1, on 06/21/11 at 5:20pm, revealed the nurse was not aware the gloves were not changed after removing the soiled dressing and not aware of the policy and procedure for hand washing after removing gloves. The LPN stated not changing gloves, not washing hands, and dragging the clean dressing across the Resident's abdomen could cause cross-contamination and place the resident at risk for an infection.</p> <p>Interview with the Marsh House Nurse Leader, on 06/23/11 at 3:40pm, revealed he had been employed with the facility for one (1) month. The Nurse Leader was not aware there was training on infection control with dressing changes. The Nurse Leader stated not changing gloves and not washing hands during dressing changes could potentially place the resident at risk for infection. He stated he had not been monitoring the nurses for infection control practices during dressing changes.</p> <p>Interview with the Marsh Household Coordinator, on 06/23/11 at 4:05pm, revealed improper</p>	F 441	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186380	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2011
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F 441	<p>Continued From page 27</p> <p>Infection control practices during dressing changes could potentially cause a wound to worsen or place the resident at risk for an infection. She further revealed she did not currently monitor for infection control or technique during dressing changes.</p> <p>Interview with the Director of Nursing, on 06/23/11 on 5:05pm, revealed improper dressing technique and infection control practice could potentially place the resident at risk for an infection. She stated she tracked the audits performed by the infection control nurse and also performed her own random audits and observed nurses perform dressing changes. However, she was unable to recall when the last observation was done and did not produce an auditing tool upon request. She further revealed nurses are trained on infection control practices during dressing changes at skills check-off and during in-services.</p> <p>Interview with the Infection Control Nurse, on 06/23/11 at 5:20pm, revealed infection control is monitored by randomly observing dressing changes. She stated if a problem was noted during random audits an in-service would be completed at that time. She was unable to recall when the last random in-service was completed. She stated dressing change technique and infection control practices were recently covered during an in-service on 06/03/2011. She further revealed that this topic was also covered during a skills check-off which was done annually in June.</p> <p>Review of the training completed on 06/03/11 regarding wound assessment and documentation revealed it did not include infection control practices during dressing changes.</p>	F 441	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
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F 441	Continued From page 28  Review of annual check-off for sterile dressing application did not include changing gloves after removing soiled dressing or hand washing between donning gloves.  2. Observation of the Marsh House of guest bathroom, by dining room on 06/21/11 at 3:10pm, revealed no soap available for handwashing. Observation, on 06/21/11 at 4:00pm, of an unsampled resident coming from the guest bathroom, revealed no soap available for handwashing. Observation of the guest bathroom, on 06/22/11 at 8:30am, revealed no soap in the guest bathroom. Observation, on 06/22/11 at 12:30pm, revealed a visitor coming out of the guest bathroom and no soap was available for handwashing. Observation, on 06/22/11 at 5:40pm, revealed a caretaker coming out of the guest bathroom and no soap was available for handwashing.  Review of Homemaker Daily Responsibilities revealed clean and sanitize common bathroom and staff bathroom twice daily.  Interview with Homemaker #7, on 06/23/11 at 10:05am, revealed homemakers are responsible for cleaning the guest bathroom. There was no checklist to follow for cleaning the bathrooms. However they checking to make sure floors, commode, and sink are cleaned and restock toilet paper. The homemaker stated checking the soap was not one of the steps.  Interview with Homemaker #6, on 06/23/11 at 3:00pm, revealed wall soap dispenser in the guest bathroom had not been filled due to being	F 441		

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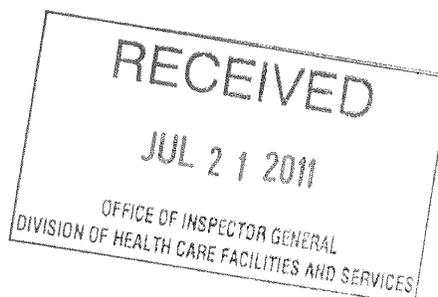
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2011
NAME OF PROVIDER OR SUPPLIER  MASONIC HOME OF LOUISVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 240 MASONIC HOME DRIVE MASONIC HOME, KY 40041	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 441	<p>Continued From page 29</p> <p>told to wait till a counter hand pump arrived. The homemaker did not know who was responsible for ordering or delivering hand pumps for soap. The homemaker stated not washing hands with soap could cause the spread of germs and infection.</p> <p>Interview with the Marsh House Nurse Leader, on 06/23/11 at 3:40pm, revealed there is no checklist for the homemakers when cleaning the bathrooms, and no current monitoring system in place to ensure bathrooms have soap for handwashing. Improper handwashing could potentially cause the spread of bacteria.</p> <p>Interview with the Marsh Household Coordinator, on 06/23/11 at 4:05pm, revealed not having soap available for handwashing is an infection control issue and could potentially lead to the spread of bacteria. She stated she does randomly monitor the guest bathroom but did not notice there was no soap. The Household Coordinator stated the current monitoring system was not working to ensure supplies are readily available for handwashing.</p> <p>Interview with the Infection Control Nurse, on 06/23/11 at 5:20pm, revealed improper handwashing could lead to the spread of infection. She stated she does monitor for infection trends and randomly audits handwashing technique. She stated she does not monitor for availability of hand hygiene supplies.</p> <p>3. Review of the clinical record for Resident #18</p>	F 441	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  06/23/2011
NAME OF PROVIDER OR SUPPLIER  MASONIC HOME OF LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 240 MASONIC HOME DRIVE MASONIC HOME, KY 40041		
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F 441	Continued From page 30 revealed an admission date of 05/19/11 and status post back surgery. The resident was to receive therapy services with a goal to return to independent living after completion. The facility assessed the resident to have a cognition deficit and required staff assistance with bed mobility, transfers, and ambulation. On 05/23/11, the nurse documented the resident was found on the floor between the bed and wall at 4:03am. The resident sustained a skin tear to the left knee and abrasion to the lateral left ankle. Treatment was provided. On 06/09/11 a wound culture of the left ankle was obtained with findings of MRSA (Methicillin Resistant Staph Aureus). Antibiotic medication was ordered for 10 days.  Observation of a wound treatment for the left ankle on 06/23/11 at 2:50pm revealed the nurse failed to wash her hands after removing soiled gloves and putting on clean gloves.	F 441			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185388	DIV (X2) MULTIPLE CONSTRUCTION AND SERVICES A. BUILDING 02 - SAM SWOPE CARE CENT B. WING _____	(X3) DATE SURVEY COMPLETED  06/21/2011
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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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K 000	INITIAL COMMENTS  A Life Safety Code survey was initiated and concluded on 06/21/2011. The facility was found to not meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".	K 000	<i>This plan of correction is being submitted in compliance with specific regulatory compliance. Neither its completion nor content is to be construed as an admission by the provider of the validity of any findings or citations contained herein.</i>	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2  This STANDARD is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions. The deficiency had the potential to affect all smoke compartments, staff and residents. The facility is licensed for one hundred and sixty seven (167) beds with a census of one hundred twenty one (121) residents on the day of the survey.  The findings include:  Record review, on 06/21/2011 at 4:20 PM, with the Acting Maintenance Director revealed the fire drills were not being conducted at unexpected	K 050	K 050 SS=F 1) The quarterly fire drill was conducted on 7/8/2011 at an unexpected time and varied condition. 2) No residents were affected by the cited deficiency. 3) Maintenance staff was educated by the Director of Maintenance on 7/15/2011 on ensuring fire drills are conducted at unexpected times under varied conditions. 4) Director of Maintenance will submit the fire drill reports to quality assurance team quarterly. 5) Compliance Date: 7/23/2011	

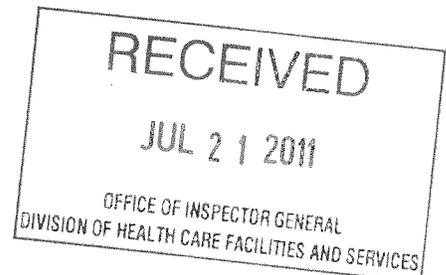
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE  
*X [Signature]* *X Executive Director X 7/21/11*

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

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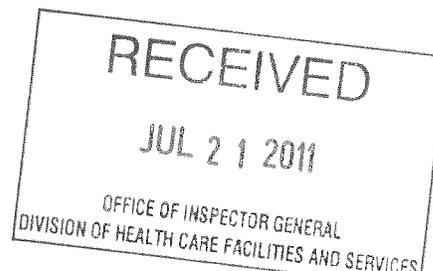
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186388	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SAM SWOPE CARE CENT B. WING _____	(X3) DATE SURVEY COMPLETED  06/21/2011
NAME OF PROVIDER OR SUPPLIER  MASONIC HOME OF LOUISVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 240 MASONIC HOME DRIVE MASONIC HOME, KY 40041	
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K 050	Continued From page 1 times under varied conditions.  Interview, on 06/21/2011 at 4:20 PM, with the Acting Maintenance Director revealed that he was unaware that fire drills were not being conducted as required.  Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.  K 108 SS=F NFPA 101 LIFE SAFETY CODE STANDARD Alarms, emergency communication systems, and illumination of generator set locations are in accordance with NFPA 70, 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain its generator in accordance with NFPA 76, 99, 101, 110, and the National Electrical Code ( NFPA 70 ) requires the facility to have a emergency illumination located at the transfer switch and at the generator location. The deficient practice has the potential to affect all smoke compartments, residents, and staff. The facility is licensed for one hundred and sixty seven (167) beds, with a census of one hundred twenty one (121) the day of the survey.  The findings include:  An observation, on 06/21/2011 at 3:35 PM,	K 050	
K 108 SS=F		K 108	K 108 SS=F 1) Emergency illumination was installed on 6/28/2011 at the generator location and transfer switch. 2) No residents were affected by the cited deficiency. 3) ) Maintenance staff was educated by the Director of Maintenance on 7/15/2011 on how to check the emergency illumination at generator and transfer switch is in compliance with the NFPA 70 on a monthly basis. 4) Director of Maintenance will submit the inspection results to quality assurance team monthly. 5) Compliance Date: 7/23/2011



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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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K 108	<p>Continued From page 2</p> <p>revealed the generator had no emergency illumination at the transfer switch and at the generator location.</p> <p>An interview, on 06/21/2011 at 3:36 PM, with the Acting Maintenance Director revealed that he was not aware that the generator and transfer switch had to have emergency illumination.</p> <p>K 147 SS=D NFFA 101 LIFE SAFETY CODE STANDARD</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: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. This deficient practice affected one (1) smoke compartment, residents, staff, and visitors. The facility is licensed for one-hundred and sixty seven (167) beds with a census of one-hundred and twenty-one (121) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/21/2011 at 3:30 PM, with the Acting Maintenance Director revealed that the electrical panels located in the G Basement had items stored in front of the panels and obstructing access.</p> <p>Interview, on 06/21/2011 at 3:30 PM, Acting Maintenance Director revealed that the stored items should not have been located in front of the electrical panels.</p>	K 108	<p>K 147 SS=D</p> <ol style="list-style-type: none"> <li>1) Items stored in front of the electrical panels were removed.</li> <li>2) No other electrical panels were found to be with obstructed access. No residents were affected by the cited deficiency.</li> <li>3) Maintenance staff was educated by the Director of Maintenance on 7/15/2011 on how to check electrical panels monthly to ensure there is sufficient access and working space.</li> <li>4) Director of Maintenance will submit the inspection results to quality assurance team monthly.</li> <li>5) Compliance Date: 7/23/2011</li> </ol>



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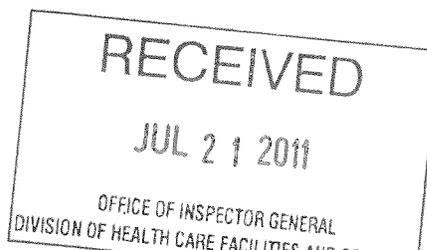
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K 147	Continued From page 3  Reference: NFPA 70 (1999 edition)  110-26. Spaces  About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147		
K 211 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers shall have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623  This STANDARD is not met as evidenced by: Based on observation and staff interview	K 211	K 211 SS=F 1) All alcohol based hand rub was removed from the cited dispensers on 6/22/2011. 2) No other alcohol based hand rub dispensers were installed over or adjacent to an ignition source. 3) All cited alcohol based hand rub dispensers were relocated on 7/23/2011 to a surface not over or adjacent to a ignition source. 4) Nurse leader and Household Coordinator and selected caregivers who are assigned to each house will be educated by Executive Director and Director of Nursing on how to conduct weekly rounds to ensure alcohol based hand rub dispensers are not installed over or adjacent to an ignition source.	



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K 211	<p>Continued From page 4</p> <p>conducted on 06/21/201, it was determined the facility failed to ensure that Alcohol Based Hand Rub dispensers were not installed over or adjacent to an ignition source, per NFPA standards. The deficiency had the potential to affect all smoke compartments, residents, staff and visitors. The facility is licensed 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>Observation, on 06/21/2011 between 10:30 AM and 3:30 PM, with the Acting Maintenance Director, revealed Alcohol Based Hand Rub dispensers were installed over or adjacent to the light switch in rooms throughout the facility.</p> <p>Interview, on 06/21/2011 at 10:30 AM, with the Acting Maintenance Director revealed he was unaware that Alcohol Based Hand Rub dispensers were prohibited to be mounted over or adjacent to an electrical ignition source.</p> <p>Reference:</p> <p>Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> <li>o The corridor is at least 6 feet wide</li> <li>o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)</li> <li>o The dispensers have a minimum spacing of 4 ft from each other</li> </ul>	K 211	<p>Findings from rounds will be addressed immediately with the house leaders and presented monthly to the quality assurance team until decision is made to discontinue.</p> <p>5) Compliance Date: 7/23/2011</p>



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K 211	Continued From page 6 o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211		

