

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

PRINTED: 10/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185378	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/28/2015
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF SHELBYVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 711 FRANKFORT ROAD SHELBYVILLE, KY 40066		
(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 Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/23/15 as alleged.	{F 000}			

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

TITLE

(X6) DATE

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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185378	(Y2) Multiple Construction A. Building _____ B. Wing _____	(Y3) Date of Revisit 10/28/2015
Name of Facility MASONIC HOME OF SHELBYVILLE		Street Address, City, State, Zip Code 711 FRANKFORT ROAD SHELBYVILLE, KY 40066

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0281 Reg. # 483.20(k)(3)(i) LSC _____	Correction Completed 10/23/2015	ID Prefix F0441 Reg. # 483.65 LSC _____	Correction Completed 10/23/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <i>MB</i>	Reviewed By <i>VT</i>	Date: 10/29/15	Signature of Surveyor: <i>Melanie Grynstein</i>	Date: 10/29/15
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 10/1/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		

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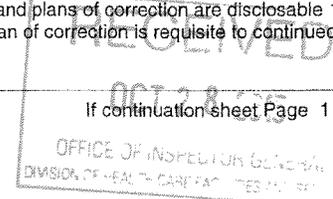
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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 09/29/15 and concluded on 10/01/15 with deficiencies cited at the highest scope and severity of an "E".	F 000	The preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure staff followed their policy regarding standards of practice for one (1) of nineteen (19) sampled residents and one (1) unsampled resident, Unsampled Resident A. LPN #1 administered an intramuscular (IM) injection to Unsampled Resident A, and failed to aspirate for blood prior to injecting the medication per facility policy; however, aspirated after the injection was completed and obtained blood in the hub of the needle. The findings include: Review, of the facility's policy regarding Intramuscular Medication Administration, not dated, revealed after positioning the resident, selecting the site for the injection, and cleaning the site with alcohol, the nurse was to insert the needle at a 90-degree angle, using a quick dart-like thrust. The nurse was to then pull back on the plunger to see if the needle was in a blood vessel. If blood appeared, the needle was to be	F 281	1. Un-sampled Resident A was identified as being affected by the issue identified. The facility has implemented corrective actions to address the identified issue in items 3, 4, and 5 below. <ul style="list-style-type: none"> The PCP was called on 9/30/15 by the Unit Coordinator to inform of injection procedure used by LPN#1 and that blood was in the hub of the syringe following injection. No new orders were obtained. RP was notified on 9/30/2015 by the Unit Coordinator regarding IM injection procedure. Unit Coordinator monitored the neighbor for adverse events on 9/30/15 with no adverse events noted. The Unit Coordinator ensured there were adequate sized syringes to administer medication injection in one syringe on 9/30/15. The Unit Coordinator provided re-education to LPN #1 on 9/30/15 regarding facility policy on administering IM injection. The Unit Coordinator observed LPN #1 perform a return demonstration of an IM injection on 10/2/15. Proper procedure was followed per facility policy. 2. No other residents were determined to be affected by the identified issue. This was determined because no other residents were receiving IM injections on the hall which LPN#1 was covering. However, the facility has implemented corrective actions to address the issue identified in items 3, 4, and 5 below. 3. The facility has initiated the following corrective measures to ensure the identified deficient practice does not reoccur as follows: <ul style="list-style-type: none"> New Hire Orientation checklists for Nurses was reviewed by the Educational Director and DON on 10/2/15 to ensure inclusion of IM injection administration and selection of appropriate size syringe. The New Hire Worksheet for Licensed Staff was revised by the Educational Director and DON on 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Robert N. Cray</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>X 10-26-15</i>
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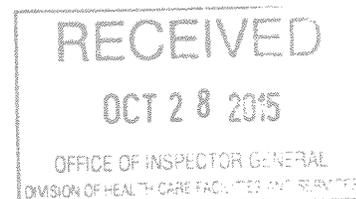
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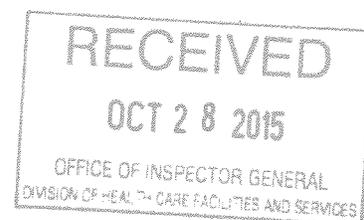
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F 281	<p>Continued From page 1</p> <p>withdrawn, new equipment and medication was to be secured and the procedure was to be repeated.</p> <p>Review, of the Lippincott Manual of Nursing Practice, Tenth Edition, 2014, General Considerations for Intramuscular Injections, page 1426, revealed after penetrating the injection site, aspirate (pull back on the syringe's plunger) to check for a blood vessel puncture. If blood vessel puncture occurred, remove the needle, discard, and start again.</p> <p>Review, of the clinical record for Unsampled Resident A, revealed the facility admitted the resident on 11/26/13 with diagnoses of Hypothyroidism, Type 2 Diabetes, Primary Hypertension, Atrial Fibrillation, Heart Failure, and a personal history of Urinary Tract Infections (UTIs). On 09/29/15, Unsampled Resident A was diagnosed with a UTI and the physician ordered Ertapenem Gram (GM) 1 to be administered IM once daily for ten (10) days. The first dose of the medication was administered on 09/30/15 by Licensed Practical Nurse (LPN) #1.</p> <p>Observation, on 09/30/15 at 9:25 AM, revealed LPN #1 reconstituted the Ertapenem 1 GM with 3.2 milliliters (mls) of 1% Lidocaine Solution, using a 10 ml syringe to accommodate the volume of medication to be prepared. Once LPN #1 prepared the medication, she then drew up the reconstituted medication from the vial into two (2) separate 3 ml syringes, as she stated the medication would not fit into just one 3 ml syringe. However, LPN #1 also stated that residents usually did not like receiving two (2) injections for delivery of the medicine. LPN #1 then proceeded to take the syringes of medication to Unsampled</p>	F 281	<p>10/6/15 to require IM injection return demonstration during the orientation process.</p> <ul style="list-style-type: none"> • Re-education was provided to all Licensed Nursing staff on 10/2/2015 by the Educational Director on the Administration of IM injections and selection of appropriate syringe size. • Return demonstrations have been conducted for all Licensed Nurses by the Educational Director, Unit Coordinators, ADON, and DON beginning 10/2/15 and completed on 10/22/15. <p>4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows:</p> <ul style="list-style-type: none"> • Nursing Audit (N-14) "Review of Medication Pass" was reviewed by the Quality Assurance Committee (QAC) to ensure inclusion of proper administration of IM injection. • The QA Committee met on 10/6/15 to review the Preliminary Plan of Correction for F-281 as presented by the DON and Educational Director. Recommendations were made. • The QA Committee met on 10/20/15 to review the final POC. <p>5. The Quality Assurance Committee will review required audits and supportive documentation to ensure effectiveness of the compliance plan and make revisions as necessary on an ongoing basis completed by</p>	10/23/2015	



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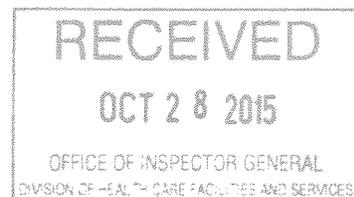
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F 281	<p>Continued From page 2 Resident A.</p> <p>Continued observation, revealed after positioning Unsampled Resident A on his/her left side, LPN #1 selected the injection site, the gluteal area of the resident's right hip. LPN #1 cleansed the skin at the site with alcohol and administered the first injection which contained 3 ml of the reconstituted Ertapenem. LPN #1 did not pull back on the plunger (did not aspirate) to ensure the needle did not hit a blood vessel, but proceeded to inject the medication. After the medicine was delivered, LPN #1 pulled back on the plunger and stated she did so to be sure the needle did not hit a vein. LPN #1 then cleansed another site on Unsampled Resident A's right gluteal area with alcohol and administered the remaining medication (about 0.1ml) via a second injection. Once again LPN #1 did not pull back with the plunger (did not aspirate) prior to delivering the medication. When LPN #1 removed the second syringe/needle from the resident a small amount of red substance (about 0.1-0.2 ml) was observed in the barrel of the syringe.</p> <p>Interview, on 09/30/15 at 10:02 AM, with LPN #1 revealed she thought the red substance in the syringe used to deliver Unsampled A's medication was blood, and she said this could have meant the needle hit the vein while she administered the second injection. LPN #1 stated she was supposed to aspirate before administering medication by the intramuscular route, but that she failed to do so. LPN #1 stated she was supposed to pull back slightly on the syringe prior to administering the injection to ensure the needle entered the muscle rather than a vein. LPN #1 stated Unsampled Resident A's antibiotic was ordered to be administered in the muscle, not in</p>	F 281			



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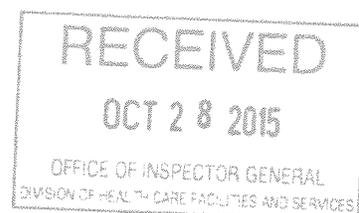
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F 281	<p>Continued From page 3 the vein.</p> <p>Interview, on 09/30/15 at 3:30 PM, with the Magnolia Unit Coordinator, revealed prior to actually injecting medication, nurses were to pull back on the syringe's plunger to determine if the needle had hit a blood vessel, and to prevent administering the medication incorrectly. The Unit Coordinator stated the facility kept six (6) ml syringes on hand and that the larger syringe should have been used to deliver Unsampled Resident A's medication. She stated providing the medicine via one injection would have prevented additional discomfort experienced from the second injection.</p> <p>Interview, on 10/01/15 at 3:00 PM, with the Director of Nursing (DON) revealed the Centers for Disease Control (CDC) guidance did not indicate aspiration was necessary prior to giving an intramuscular injection (IM). However, she stated, according to the facility's policy, licensed nurses were to pull back slightly with the syringe's plunger (check for aspiration of blood) prior to administering an intramuscular injection. She stated the appropriate size syringe and needle should be selected for the amount of IM medication to be administered. The DON stated that 1 injection would be preferred over 2 injections to minimize the resident's discomfort and to prevent unnecessary breaks in the integrity of the resident's skin. She stated the facility kept six (6) ml syringes on hand and the larger syringe could have been used to deliver just one (1) injection to Unsampled Resident A.</p> <p>Interview, on 10/01/15 at 5:10 PM, with the Registered Pharmacist (RPh), employed by the facility's contracted Pharmacy Service, revealed</p>	F 281			



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F 281	Continued From page 4 Unsampled Resident A was on a blood thinner which might make him/her slightly more prone to bleeding and the blood thinner could enhance the return of blood in the barrel of the syringe with an injection.	F 281			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	1. Resident #7 was identified as being affected by the issue identified. The facility has implemented corrective actions to address the identified issue in items 3, 4, and 5 below. • Verbal and written education was provided to the family of Resident #7 regarding use of PPE when entering/exiting a Contact Isolation room and hand hygiene on 10/2/15 and 10/5/15 by the Unit Coordinator. • Resident Summary for Resident #7 was revised on 10/1/15 by the ADON to reflect "In Room contact isolation for C. Diff of the stool: All services provided in room". • LPN #1 received re-training on Proper Sharps disposal on 10/2/15 by the Unit Coordinator and on 10/5/15 by the Infection Preventionist Nurse. LPN #1 received re-training by the Unit Coordinator and performed return demonstration of proper donning and doffing of PPE and hand washing in regards to a Contact Isolation Room for Clostridium difficile on 10/2/15. • LPN #2 received re-training on Proper hand hygiene during medication administration on 10/2/15 by the Unit Coordinator. Return demonstration during a medication pass observation was completed with LPN #2 on 10/9/15 by the Educational Director. • Signage was posted on wall near Resident #7 door on 10/2/15 by the Infection Preventionist Nurse stating Contact Precautions with required PPE and hand hygiene before entering and exiting. 2. Other residents were determined to have the potential to be affected by the identified issue. The facility has implemented corrective actions to address the identified issue in items 3, 4, and 5 below. • Verbal and written education was provided to the family of other residents on isolation regarding use of PPE when entering/exiting a Contact Isolation room and hand hygiene on 10/2/15 and 10/5/15 by the Unit		



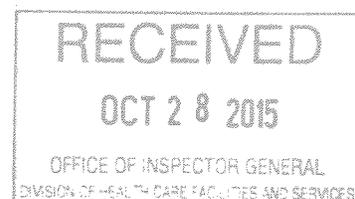
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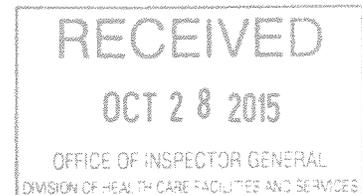
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F 441	Continued From page 5 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to have an effective system in place to ensure staff followed infection control practices related to hand hygiene by staff, use of Personal Protective Equipment (PPE) by staff and visitors, and disposal of sharps by staff during medication pass. Two (2) of three (3) Licensed Practical Nurses, (LPN #1 and #2). LPN #1 was observed in Resident #7's room, to untie an isolation gown with contaminated gloves, remove the gown then the contaminated gloves leaving the room without hand washing. LPN #1 used hand sanitizer to sanitize her hands after providing resident care when the sanitizer was ineffective against Resident #7's infection of Clostridium difficile Colitis. LPN #1 disposed of a syringe and needle without ensuring the sharps went down into the sharps container during medication pass. LPN #2 prepared medications and cleaned up a spill after which she administered medication without hand washing. One (1) of one (1) visitor was observed not using personal protective equipment (PPE) while adjusting the sheets on the bed and placing Resident #7's soiled personal clothing in a bag. Two (2) of five (5) Certified Nurse Assistants (CNA #2 and #3) were observed to enter the Resident #7's contact isolation room	F 441	<ul style="list-style-type: none"> Resident Summary for other residents on isolation was revised on 10/1/15 by the ADON to reflect "In Room contact isolation for C. Diff of the stool: All services provided in room". LPN #1 received re-training on Proper Sharps disposal on 10/2/15 by the Unit Coordinator and on 10/5/15 by the Infection Preventionist Nurse. LPN #1 received re-training by the Unit Coordinator and performed return demonstration of proper donning and doffing of PPE and hand washing in regards to a Contact Isolation Room for Clostridium difficile on 10/2/15. LPN #2 received re-training on Proper hand hygiene during medication administration on 10/2/15 by the Unit Coordinator. Return demonstration during a medication pass observation was completed with LPN #2 on 10/9/15 by the Educational Director. Signage was posted on wall near all resident's doors who were on isolation on 10/2/15 by the Infection Preventionist Nurse stating Contact Precautions with required PPE and hand hygiene before entering and exiting. <p>3. The facility has initiated the following corrective measures to ensure the identified deficient practice does not reoccur as follows:</p> <ul style="list-style-type: none"> Re-education was provided to all staff by the Infection Preventionist Nurse on correct use of PPE when entering and exiting an Isolation Room and proper Hand Hygiene on 10/2/15, 10/7/15, and 10/13/15. Re-education was provided by the Infection Preventionist and Unit Coordinators for all licensed staff regarding proper Sharps Disposal and appropriate Hand Hygiene during medication administration on 10/2/15 and 10/19/15. The New Hire Orientation checklists for all departments were reviewed by the Educational Director and DON to ensure inclusion of proper Hand Hygiene and use of PPE when entering and exiting an Isolation Room on 10/12/15. The New Hire Orientation checklist for Nurses and Medication Techs were reviewed by the Educational Director and DON to ensure Proper hand hygiene during medication administration on 10/12/15. The New Hire Orientation checklist for Nurses was reviewed and revised by the Educational Nurse and DON to include Proper Sharps Disposal on 10/12/15. <p>4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows:</p> <ul style="list-style-type: none"> The Infection Control Committee (ICC) selected a new visible signage, in accordance with CDC's recommendation, to be placed on all neighbors' doors upon when placed on 	



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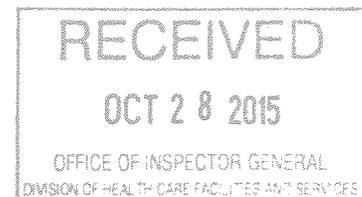
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F 441	Continued From page 6 without donning PPE. CNA #2 entered the room to deliver a clean bedpan, opened the bathroom door with bare hands and CNA #3 entered to turn off the call light and bring the resident water with bare hands. The findings include: Review of the facility policy regarding Contact Precautions, not dated, revealed Clostridium difficile could be transmitted both directly and indirectly. Indirect contact would involve someone coming into contact with an inanimate object that had been in the resident's environment. Team members would use isolation precautions when caring for a resident who had a communicable disease that could be transmitted by direct contact with the resident. The staff was to wash their hands with soap and water before and after each resident contact. Review of the facility's policy regarding Hand Washing Policy, revised July 2013, revealed hands were to be washed before handling medications and after each resident's medication pass. In addition, if hands were not visibly soiled, hands may be decontaminated with an alcohol based hand rub, and when in doubt, wash hands. Review of the facility's policy regarding Sharps Disposal, dated August 2010, revealed sharps waste included needles, scalpels, razors or other sharp instruments used for resident care procedures. All such instruments should be segregated from other waste and placed in puncture resistant containers immediately after use. Immediately or as soon as possible after use, contaminated sharps should be placed in a sharps container.	F 441	isolation, indicating hand hygiene and required PPE for all staff and visitors. Completed 10/5/15. • The ICC selected Isolation Educational material from the Advancing Excellence's Disrupt Infections Seminar, which was attended by our Infection Preventionist and Director of Nursing on 10/8/15, to be readily available outside the isolation rooms. Completed 10/9/15 • The ICC made revisions to the Isolation Process (Checklist) which requires the nurse to provide verbal education (Precautions, PPE, hand hygiene) to RP upon notifying them of the neighbor being placed on isolation on 10/19/15. A written "Transmission Based Precautions Education" will be signed by the RP indicating they have received verbal and written information. Nurses were in-serviced by the Educational Director on providing verbal and written information to the RPs on 10/19/15. • The Facility's Infection Control Policies regarding Isolation Technique were reviewed by the Infection Control Committee and compared to the CDC's recommendation to ensure compliance on 10/5/15. • The ICC reviewed the Infection Control Annual CQI calendar with revisions to conduct IC-6 Audits weekly rather than monthly on the Isolation Review which includes return demonstration of donning and doffing PPE and hand hygiene for isolation rooms. Completed 10/2/15 • ICC presented preliminary action plan for F441 POC to Quality Assurance Committee (QAC) • QA reviewed and accepted the completed plan of correction that was presented by the Infection Control Committee on 10/20/2015 5. The Quality Assurance Committee will review required audits and supportive documentation to ensure effectiveness of the compliance plan and make revisions as necessary on an ongoing basis completed by	10/23/2015	



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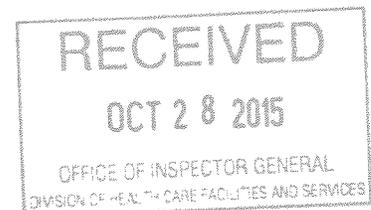
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F 441	Continued From page 7 1. Review of the clinical record for Resident #7, revealed the facility admitted the resident on 07/14/15 with diagnoses of Clostridium difficile Infection (C. diff), Congestive Heart Failure and Hypertension. The resident had nonhealing fractures of the right leg from previous falls prior to admission. Review of Resident #7's admission Minimum Data Set (MDS) assessment, dated 08/07/15, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of 15 and determined the resident was alert, oriented and able to be interviewed. The resident had returned from a hospital stay for Congestive Heart Failure and was in isolation for a bowel infection. The facility further assessed the resident as requiring total assistance with transfers and extensive assistance for turning, dressing, grooming, and hygiene. Further the resident was incontinent of bowel and bladder. The resident received antibiotics for the infection. Review of Resident #7's care plan, dated 09/30/15, revealed the resident had an active infection with Clostridium difficile and required isolation. The resident was experiencing mood symptoms of crying and feeling down. Interview with CNA #2, on 09/29/15 at 11:01 AM, revealed the Resident Summary contained instructions for the CNAs to provide care to a resident. Review of the Resident Summary, dated 09/29/15, revealed Resident #7 required contact isolation for C. diff and experienced incontinent episodes. The resident used a bedpan related to	F 441			



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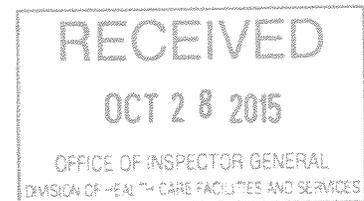
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F 441	<p>Continued From page 8</p> <p>a fracture of the right leg. The resident was prescribed bedrest by the physician.</p> <p>Observation of Resident #7, on 09/29/15 at 10:03 AM, revealed the resident had turned the call light on and when CNA #3 entered the room without PPE and turned the call light off. The resident requested water and the CNA left and returned with water. The CNA donned gloves prior to entering the room; however, she did not don a gown to stand next to the bed and deliver the water.</p> <p>Interview with CNA #3, on 09/29/15 at 12:21 PM, revealed she was educated by the facility on isolation. She stated since some residents were allowed out of their rooms while on isolation, she felt she did not need to wear a gown in the resident's room unless she provided direct care. She stated germs could be passed to other residents.</p> <p>Observation of Resident #7, on 09/30/15 at 8:20 AM, revealed CNA #2, entered Resident #7's room without PPE, opened the bathroom door and left a new bedpan for the resident.</p> <p>Interview with CNA #2, 09/30/15 at 4:19 PM, revealed she did not wear PPE when entering Resident #7's room as she did not intend to provide direct care. She stated this was the way she understood isolation. She stated she was aware the resident had an infection of the bowel. She stated it was possible to spread an infection to other residents.</p> <p>Observation of Resident #7, on 09/30/15 9:25 AM, revealed LPN #1 removed PPE by untying the neck of the gown while wearing contaminated</p>	F 441		



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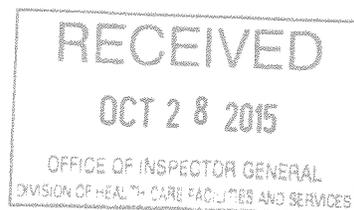
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F 441	<p>Continued From page 9</p> <p>gloves and removing the gown first. She removed her gloves next and exited the room without handwashing. She was noted to apply hand sanitizer on the way out of the room.</p> <p>Interview with LPN #1, on 09/30/15 at 9:50 AM, revealed she had received education from the facility regarding isolation; however, she was not aware the gloves were removed first when exiting a isolation room. She stated that Resident #7 had C. diif in the stool and alcohol did not kill the spores. She stated she should have washed her hands with soap and water before leaving the isolation room to prevent spreading the infection.</p> <p>Interview with the Director of Nursing, on 10/01/15 at 3:33 PM, revealed nursing staff were trained on contact precautions. She stated staff could spread infection directly and indirectly.</p> <p>2. Observation, on 09/30/15 at 8:10 AM, during the morning medication pass, revealed LPN #2, failed to wash her hands or use hand sanitizer after touching the lidded trash can affixed to the medication cart.</p> <p>LPN #2 spilled Med Pass supplement several times while attempting to pour it into a plastic 30 milliliter (ml) cup. As LPN #2 poured the Med Pass, she spilled the liquid onto the med cart, used tissues to clean up the spills, and lifted the trash can lid to deposit the soiled tissues. LPN #2 touched the lid and inside the trash can with her hands, five (5) separate times, and she failed to use the hand sanitizer available at the med cart or wash her hands with soap and water. LPN #2 continued to prepare the Med Pass supplement for the next resident on her med pass assignment. In addition, LPN #2 opened the unit</p>	F 441			



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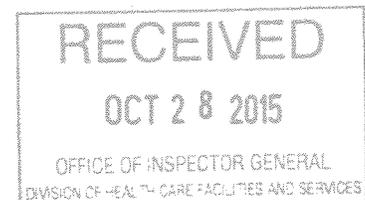
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F 441	<p>Continued From page 10</p> <p>dose blister packs of medications for the resident and dropped them into a med cup, but had still not sanitized her hands after touching the inside of the trash can and it's lid.</p> <p>Interview, on 10/01/15 at 10:25 AM, with LPN #2 revealed she should have washed or sanitized her hands after she touched the trash can affixed to the side of the med cart. LPN #2 stated the med cart trash can was considered dirty, and by touching the trash can, and then touching the med cart, she felt she contaminated the med cart's surface where she was preparing medications for residents. LPN #2 stated her initial thought was she should have put away the medications she was setting up and washed her hands at a nearby sink. LPN #2 stated she thought she just froze up. LPN #2 stated she typically kept hand sanitizer on her med cart and had hand sanitizer available for use when she was conducting the medication pass on the morning of 09/30/15. LPN #2 stated the facility had provided hand washing/hand hygiene education within the past six (6) months.</p> <p>3. Observation, on 09/30/15 at 9:45 AM, revealed LPN #1 attempted to deposit a 10 ml syringe and needle into the sharps container affixed to the med cart when she was preparing an intramuscular injection. The nurse placed the syringe and needle in a concave cradle on top of the sharps container, but did not ensure it was deposited all the way into the sharps container before she walked away from the med cart. The sharps container was at hands reach and eye level for anyone passing by, including residents/visitors or others who would propel through the hallway in a wheelchair. LPN #1 proceeded to take medication to a resident's</p>	F 441			



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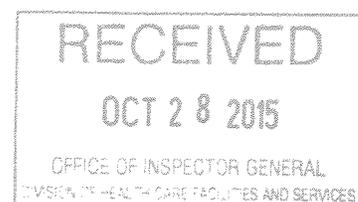
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F 441	<p>Continued From page 11</p> <p>room, and knocked on the resident's door. At that point, the surveyor asked LPN #1 to come to the med cart and observe the syringe/needle that was lying on top of the sharps container. The nurse then deposited the needle/syringe all the way into the sharps container.</p> <p>Interview, on 09/30/15 at 9:52 AM, with LPN #1 revealed it was not "ok" for the needle to be left resting on top of the sharps container. LPN #1 stated a resident could obtain the syringe and she did not notice she had not completely deposited the needle into the sharps container.</p> <p>Interview, on 09/30/15 at 3:30 PM with the Magnolia Unit Coordinator, revealed she expected nurses assigned to medication pass to wash and/or sanitize their hands whenever they touched something that would be considered unclean, and the trash can at the med cart would be considered unclean. The Unit Coordinator stated staff were periodically observed on their med pass process and technique by corporate staff and by staff from the organization that provided the facility with contracted pharmacy services.</p> <p>Interview, on 10/01/15 at 2:40 PM, with the Director of Nursing (DON) revealed staff passing medications should, at a minimum, use hand sanitizer any time their hands became contaminated by touching items considered dirty. The DON stated the trash can on the med cart and its lid would be considered dirty, and the nurse should have sanitized her hands after touching it and before continuing to prepare the resident's supplement and medications.</p> <p>The DON stated sharps (needles/syringes)</p>	F 441			



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F 441	Continued From page 12 should be completely deposited in the facility's sharps containers. The facility's residents would have access to any sharp item not completely secured and out of reach. The DON stated her concern was the potential a cognitively impaired resident could have accessed the syringe/needle that was not deposited in the sharps container, and all of the testing and follow up that would have been necessary if there had been a needle stick injury.	F 441			



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NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF SHELBYVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 711 FRANKFORT ROAD SHELBYVILLE, KY 40066
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1902, 1930, 1951 and 2012</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two (2) stories, Type II (222)</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments</p> <p>FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet and dry sprinkler system.</p> <p>GENERATOR: Type II, 275 KW generator. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 09/30/15. The facility was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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.

OCT 22 2015
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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