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

PRINTED: 07/27/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE STREET ADDRESS, GITY, STATE, ZIP CODE 20 MASONIC HOME ORIVE MASONIC HOME OF LOUISVILLE SUMMARY STATEMENT OF DEFICIENCIES ((EACH DEFICIENCY MUST 8E PRECEDED BY PILL) REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 07/22/2020 and concluded on 07/22/2020. The additive was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19, Total census 135.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	(X3) DATE SURVEY COMPLETED	
MASONIC HOME OF LOUISVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 07/22/2020 and concluded on 07/22/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for	185388		185388	B. WING	<u> </u>	0.7	07/00/000	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 07/22/2020 and concluded on 07/22/2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for	l		LLE		240 MASONIC HOME DRIVE	CODE	12212020	
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ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (YE) DATE		A COVID-19 Focus was initiated on 07/07/22/2020. The fact compliance with 42 regulations and has Medicare & Medical Centers for Disease (CDC) recommende COVID-19. Total certifications and certifications are considered to the content of the conten	sed Infection Control Survey 22/2020 and concluded on cility was found to be in CFR 483.80 infection control implemented the Centers for id Services (CMS) and a Control and Prevention ed practices to prepare for insus 135.		000			

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
185388		B. WING			07/22/2020		
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF LOUISVILLE				STREET ADDRESS, CI 240 MASONIC HOME MASONIC HOME,	EDRIVE	1 07	22/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	X (EACH CORF	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPRO		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
	Survey was initiated concluded on 07/22	ed Emergency Preparedness I on 07/22/2020 and /2020. The facility was found with 42 CFR 483.73 related					
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ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN/	ATLIDE	TITLE			Y6) DATE

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(X6) DATE

Office of Inspector General

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE	(X3) DATE SURVEY COMPLETED	
100225			B. WING			07/22/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	STATE, ZIP CODE				
MASONIC HOME OF LOUISVILLE 240 MASONIC HOME DRIVE MASONIC HOME, KY 40041							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	(X5) COMPLETE DATE		
N 000	Initial Comments		N 000				
	was initiated 07/22/ 07/22/2020. The fa	ed Infection Control Survey 2020 and concluded on cility was found to be in nt to 42 CFR 483.80.		\$a			
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE