STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		155593	B. WI	NG		11/21/2022	
NAME OF P	PROVIDER OR SUPPLIER	<u>.</u>			DDRESS, CITY, STATE, ZIP COD	<b>-</b>	
					EEMASON PARKWAY		
INDIANA	DIANA MASONIC HOME HEALTH CENTER			FRANKI	LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0580	483.10(g)(14)(i)-(i	, ,					
SS=D		(Injury/Decline/Room, etc.)					
Bldg. 00		otification of Changes.					
	•	mmediately inform the					
	resident; consult v	tify, consistent with his or					
		resident representative(s)					
	when there is-						
		volving the resident which					
	, ,	nd has the potential for					
	requiring physicial	•					
		hange in the resident's					
	physical, mental, o	or psychosocial status					
	(that is, a deterior	ation in health, mental, or					
	psychosocial statu	us in either life-threatening					
		cal complications);					
	` '	r treatment significantly					
		discontinue an existing					
	form of treatment						
		to commence a new form					
	of treatment); or	wayafay ay dia ah ayya tha					
	, ,	ransfer or discharge the facility as specified in					
	§483.15(c)(1)(ii).	racility as specified in					
	- , , , , ,	notification under paragraph					
		ection, the facility must					
	, , , , ,	tinent information specified					
	•	s available and provided					
	upon request to th						
		ist also promptly notify the					
	resident and the re	esident representative, if					
	any, when there is						
	(A) A change in ro						
		ecified in §483.10(e)(6); or					
	` '	esident rights under Federal					
	· ·	gulations as specified in					
	paragraph (e)(10)						
	. ,	ust record and periodically					
	phone number of	ss (mailing and email) and					
	priorie number of	uie iesiueiii					
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURI	3	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6UDX11 Facility ID: 001133 If continuation sheet Page 1 of 15

Administrator

12/15/2022

continued program participation.

William Pierce

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			LETED	
		155593	B. W	ING		11/21	/2022
NAME OF T	DDOWIDED OF CLIDE ICE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	X.		800 FR	EEMASON PARKWAY		
INDIANA	MASONIC HOME	HEALTH CENTER		FRANK	ILIN, IN 46131		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY I		DATE
	representative(s).						
	§483.10(g)(15)						
		emposite distinct part. A					
		emposite distinct part (as					
	1	) must disclose in its					
	admission agreen						
		uding the various locations					
	that comprise the	composite distinct part,					
	and must specify the policies that apply to						
	room changes between its different locations						
	under §483.15(c)(	(9).					
			F 0:	580	F580 Notification of Changes	s <b>–</b>	12/19/2022
		on, interview, and record			Brace/Splint		
		failed to ensure the physician			Corrective action for the affected resident. The brees a		
		a physician's order was unable for 1 of 2 residents reviewed for			affected resident: The brace of		
	positioning devices				for resident #246 was placed hold temporarily and then	UII	
	positioning devices	. (Resident 270)			discontinued while therapy		
	Findings include:				clarifies the need for a brace f	or	
	<i>5</i>				resident #246. Therapy has		
	On 11/15/22 at 12:1	13 p.m., Resident 246 was			ordered a brace and new orde	ers	
		his recliner. Resident 246's			will be implemented once it is		
		g across his chest and no brace			available for use. (See		
	or edema glove wer	re visible on the left arm.			Attachment: Clinicare Fax Ord	der	
					Form)		
		38 a.m., Resident 246 was			Corrective action for		
		his recliner. Resident 246's			residents that have the potent		
	-	g across his chest and no brace			be affected: All residents with		
	or edema glove wei	re visible on the left arm.			order for a brace or splint have		
	On 11/17/22 at 10:3	30 a.m., Resident 246 was			potential to be affected. An or review was completed to iden		
		his recliner. Resident 246's			all residents in the facility with	-	
		g across his chest and no brace			order for a brace or splint. For		
	· ·	re visible on the left arm.			those residents identified, an		
	8				was completed to ensure that		
	On 11/17/22 at 2:10	0 p.m., Resident 246 was			brace or splint is available for		
		his recliner. Resident 246's			on the resident (See Attachme		1
	1	g across his chest and no brace			Brace/Splint Initial Audit). If th		
	· ·	re visible on the left arm			ordered brace or enlint was no		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED			
		155593	B. WING		11/21/2022			
		<u> </u>	CTDEET	ADDRESS, CITY, STATE, ZIP COD				
NAME OF P	PROVIDER OR SUPPLIE	3						
ΙΝΟΙΔΝΔ	MASONIC HOME	HEALTH CENTER		800 FREEMASON PARKWAY FRANKLIN, IN 46131				
	INIAGONIO I IOIVIE	HEALITICENTER	FRAIN					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
				available for use per orders, the				
		0 p.m., Resident 246 was		physician was notified to clarif	y if			
		bed. Resident 246's left arm		the brace or splint was still				
	-	his chest and no brace or		needed or if one needed to be	;			
	edema glove were	visible on the left arm.		ordered (See Attachment:				
	D 11 - 242 22			Brace/Splint Initial Audit)				
		ical record was reviewed on		3. Measures to prevent ful				
	•	m. The diagnoses included, but		deficient practice: The Admiss	sion			
	· · · · · · · · · · · · · · · · · · ·	, nontraumatic intracerebral		Chart Review form (See				
		n stem (stroke) and hemiplegia		Attachment: Admission Chart				
	(muscle weakness or partial paralysis on one side			Review) has been updated to				
	of the body that can affect the arms, legs, and			include checking for brace or				
	facial muscles) affecting left nondominant side			splint orders and if the brace of	III			
	(left side).			splint is present for use on the				
	Di	66 1. 6 11/10/20 .		resident. If the ordered brace	or			
	-	effective date from 11/10/22 to		splint is not available, the				
	· ·	"left elbow extension brace		physician will be notified for				
		on in am [morning] and		clarification of need versus	for			
		8 hours daily, edema glove to after 8 hours of wear. Check		obtaining the appropriate devi				
				the resident. A Brace/Splint A				
	skin underneath eve	ery day and evening."		(See Attachment: Brace/Splin				
	A Drogress Mate 1	oted 11/10/22 at 5:29		Audit) has been implemented	IOI			
	_	ated 11/10/22 at 5:38 p.m., 246 was cognitively intact and		documentation of auditing of				
	had a stroke that af			brace/splint use. Audits will be	;			
	nau a shoke mat al	iecieu iiis ieit siue.		conducted twice weekly for 3				
	Resident 246's Tros	ntment Administration Record		months. If 100% compliance is				
		ndicated "left elbow extension		achieved, auditing will then be				
	` ′	encourage to wear 8 hours		reduced to weekly for 3 addition months. If 100% compliance is	III			
		to left hand. Remove after 8		I				
	•	eck skin underneath every day		then achieved, auditing will be discontinued. Auditing will be				
	and evening."	ock skin underneam every day		_				
	and evening.			residents with a brace or splin order to ensure the device is	١			
	Resident 246's care	plan, initiated on 11/11/22 and		present, and that the				
		/23, indicated "focus:		documentation of use or non-	160			
	_	lteration in neurological status		is accurate. Facility nurses wil				
		oke]goal: will be free from		provided education on brace a	III			
		okejgoar: will be free from aptoms] of complications of		·				
	CVAcontractures			splint order follow through and				
	c v Acomractures	•••	1	accuracy of documentation (S	<del>CC</del>			

Attachment: Annual Survey Plan

PRINTED: 01/03/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-039				
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPI	LETED	
		155593	B. WING		11/21	/2022	
			STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF PROVIDER OR SUPPLIER			REEMASON PARKWAY				
INDIANA	MASONIC HOME	HEALTH CENTER		KLIN, IN 46131			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	The CNA (Certified	d Nursing Assistant) task sheet		of Correction Nurse Education	and		
	(specific care instru	ections for Resident 246)		POC Training Report).			
	indicated "brace to	left elbow."		4. Monitoring of corrective			
				actions: Corrective actions and	d		
	During an interview	v on 11/17/22 at 4:14 p.m., the		auditing will be discussed in the	ne		
	Director of Nursing	Services (DNS) indicated the		facility Quality Assurance and			
	facility should have	verified with the physician		Performance Improvement me	eting		
	whether Resident 2	46 required the left elbow brace		monthly for the next 6 months			
	and edema glove as indicated by the physician's admitting orders.						
	During an interview	v on 11/18/22 at 2:10 p.m.,					
	Resident 246 indica	ated he had not worn the left					
	elbow brace or eder	ma glove since his admission					
	into this facility nor	r were the items in the facility.					
	During an interview	v on 11/18/22 at 2:20 p.m., CNA					
	_	Assistant) 2 indicated she had					
	,	ent 246 "most of the time"					
		and she had never seen the					
		ma glove in his room nor on his					
	person.	greve in the reem ner on the					
	During an interview	v on 11/18/22 at 2:21 p.m., RN 3					
	_	indicated "as of today					
		nt 246's physician order was					
		Lesident 246 was to no longer					
	_	brace or edema glove.					
		<i>8</i> - · - ·					
	During an interview	v on 11/18/22 at 4:11 p.m., the					
		ident 246 was admitted with a					
		wear a left elbow brace and					
		aily basis. Resident 246's left				1	
		ema glove were not sent from					
		and so they were not					
		lity should have notified the					
		g the use of the left elbow					
		ove and obtained the					
	I That and caching gr		1	1		I	

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clarification for their use.

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If continuation sheet Page 4 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155593	B. WI	NG		11/21/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			EEMASON PARKWAY		
INDIANA	MASONIC HOME	HEALTH CENTER			LIN, IN 46131		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		v on 11/21/22 at 10:20 a.m., LPN					
		Nurse) 4 indicated at					
	· ·	t 246 had an order for the left					
		ema glove to be worn for 8					
		ent 246 was not able to wear					
	either item as they were not available in the						
	facility.						
	On 11/21/22 at 10·3	30 a.m., the DNS provided a					
	copy of the Resident Inventory Sheet, dated						
	11/10/22, and indicated it was the current						
	· ·	Resident 246. A review of the					
	inventory sheet, signed by Resident 246's family						
	member, included clothing, wheelchair, glasses,						
	toiletries, and electr	onics. The inventory sheet					
	did not include the	left elbow brace or edema					
	glove.						
	On 11/21/22 at 10:3	30 a.m., the DNS provided a					
		Compass Park - Nursing					
		of Changes, dated October					
		dicated it was the current					
		facility. A review of the					
	* *	The purpose of this policy, is					
		y promptly informs the					
		ne resident's physicianwhen					
	there is a change re-						
		nstances that require a need to					
		v treatmentdiscontinuation of					
	current treatment'	1					
	0 11/01/00 + 10 0	00 d DNG '11					
		30 a.m., the DNS provided a					
		Compass Park - Nursing					
		rders policy, dated October					
	· ·	it was the current policy in use eview of the policy indicated,					
		e nursing staff should seek					
	•	nursing starr should seek an order is unclear or unable to					
		rected by the physician "the					
	order should be clar						
	order should be clai	illeu					

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Event ID:

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If continuation sheet Page 5 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00 COMPLETED			LETED
		155593	B. W	ING		11/21	/2022
NAME OF F	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
	MASONIC HOME			800 FREEMASON PARKWAY FRANKLIN, IN 46131			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL			COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	3.1-5(a)(3)						
F 0698	483.25(I)						
SS=D	Dialysis						
Bldg. 00	§483.25(I) Dialysis	S.					
	The facility must e	ensure that residents who					
	require dialysis re	ceive such services,					
	· ·	ofessional standards of					
	practice, the comprehensive person-centered care plan, and the residents' goals and preferences.						
		and record review, the facility	F 0	698	F698 - Dialysis		12/19/2022
	failed to complete p				Corrective action for the		
		ered for 1 of 1 resident			affected resident: The chart of		
	reviewed for dialysi	is. (Resident 54)			resident #54 has been reviewe		
	Tr. 1: 1 1 1				and the needed Dialysis Orde		
	Finding includes:				orders (See Attachment: Dialy Order Set) have been added t		
	On 11/15/22 at 1:05	5 P.M., Resident 54's clinical			resident's order set list (See		
	record was reviewe	d. The Quarterly MDS			Attachment: Resident #54		
	(Minimum Data Set	t) assessment, dated 9/16/22,			Dialysis Order Set). This order	rset	
	indicated Resident	54 was cognitively intact.			includes orders to complete th	е	
	Resident 54's diagn	oses included, but were not			pre-dialysis assessment and		
		kidney disease stage 5 and			post-dialysis assessment.		
	-	ıl dialysis. Resident 54			Corrective action for		
	-	eatment three days a week			residents that have the potent		
	(Monday, Wednesd	ay, and Friday).			be affected: All residents rece	-	
					dialysis have the potential to b		
	-	ders included, but were not			affected. There are currently r	10	
	limited to:				other residents in-house that		
					require hemodialysis.		
		lysis assessment under			3. Measures to prevent fut	ure	
		time a day every Monday,			deficient practice: A Dialysis		
	wednesday, and Fr	iday, initiated on 4/1/22.			Order Set (See Attachment:		
	2 Complete neet di	alysis assessment under			Dialysis Order Set) has been		
		aiysis assessment under time a day every Monday,			created in Point Click Care to	to	
		iday, initiated on 4/1/22.			apply to any incoming residen		
	wednesday, and Fr	iday, iliilaicu oli 4/1/22.			that require hemodialysis. This order set includes orders to	•	
			- 1		I oraci ser includes oracis lo		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155593		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  11/21/2022		
	PROVIDER OR SUPPLIER		800 FF	ADDRESS, CITY, STATE, ZIP COD REEMASON PARKWAY KLIN, IN 46131		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDERS PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
TAG		S LSC IDENTIFYING INFORMATION 5 A.M., Resident 54's pre and	TAG	complete the pre-dialysis and	DATE	
	post dialysis assess	ments were reviewed from		post-dialysis assessments. Th	ne	
	9/1/22 through 11/1	16/22. A review of the		Admission Chart Review form		
	documentation indi	cated the following:		Attachment: Admission Chart	`	
				Review) has been updated to		
	- On 9/2/22 (Friday	r) the clinical record lacked a		include the addition of the dia	lysis	
	post dialysis assess	ment.		order set if applicable. A Dialy	/sis	
				Assessment Audit (See		
	- On 9/5/22 (Monda	ay) the clinical record lacked a		Attachment: Dialysis Assessn	nent	
	pre dialysis assessment.  - On 9/7/22 (Wednesday) the clinical record lacked a post dialysis assessment.			Audit) has been created to au	dit	
				completion of the pre-dialysis		
				assessment and post-dialysis		
				assessment for each dialysis		
				resident for each dialysis day.		
		nesday) the clinical record		Facility nurses will be provide	d	
	lacked both a pre di	ialysis and a post dialysis		education on completion of th	e	
	assessment.			pre-dialysis assessment and		
				post-dialysis assessment and		
		y) the clinical record lacked a		new dialysis order set in Point		
	post dialysis assess	ment.		Click Care by the date of alleg		
				compliance (See Attachment:		
		nesday) the clinical record		Annual Survey Plan of Correct	etion	
	lacked a post dialys	sis assessment.		Nurse Education and POC		
	O 0/20/02 /F : 1			Training Report).		
	post dialysis assess	y) the clinical record lacked a		4. Monitoring of corrective		
	post dialysis assess.	ment.		actions: Corrective actions an auditing will be discussed in the		
	- On 10/3/22 (Mone	day) the clinical record lacked a		facility Quality Assurance and		
	post dialysis assess:			Performance Improvement me		
	post diarysis assess.	mont.		monthly for the next 6 months	•	
	- On 10/5/22 (Wedi	nesday) the clinical record		monthly for the flext o months	·	
	lacked a post dialys					
	- On 10/10/22 (Mor	nday) the clinical record lacked				
	both a pre dialysis a					
	assessment.	- •				
		dnesday) the clinical record				
	lacked a post dialys	sis assessment.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DA			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		155593	B. WING 11/21/20			/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			EEMASON PARKWAY		
INDIANA	MASONIC HOME	HEALTH CENTER			LIN, IN 46131		
(VA) ID							075)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
TAU	REGULATORY OR LSC IDENTIFYING INFORMATION  - On 10/14/22 (Friday) the clinical record lacked a			IAU			DATE
	post dialysis assessi						
	post diarysis assessi	ment.					
	- On 10/17/22 (Monday) the clinical record lacked						
	a post dialysis asses						
	•						
	- On 10/19/22 (Wed	dnesday) the clinical record					
	lacked a post dialysis assessment.						
	- On 10/24/22 (Monday) the clinical record lacked						
	a post dialysis assessment.						
	0 10/0//00 (77/ 1 1 1 1 1 1 1 1 1						
	- On 10/26/22 (Wednesday) the clinical record lacked both a pre dialysis and a post dialysis						
	assessment.	larysis and a post diarysis					
	assessment.						
	- On 10/28/22 (Frid	lay) the clinical record lacked					
	both a pre dialysis a						
	assessment.	1					
	- On 10/31/22 (Mor	nday) the clinical record lacked					
	a post dialysis asses	ssment.					
		y) the clinical record lacked a					
	post dialysis assessi	ment.					
	On 11/7/22 (Mone	day) the clinical record lacked a					
	post dialysis assessi						
	post diarysis assessi	ment.					
	- On 11/9/22 (Wedr	nesday) the clinical record					
	lacked a post dialys	± *					
	, ,						
	- On 11/11/22 (Frid	ay) the clinical record lacked a					
	post dialysis assessi	ment.					
	·	dnesday) the clinical record					
	_	alysis and a post dialysis					
	assessment.						
		11/10/00 . 11 07 . 37					
	During an interview	v on 11/18/22 at 11:35 A.M., the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155593		A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/21/2022	
	ROVIDER OR SUPPLIER			800 FRE	DDRESS, CITY, STATE, ZIP COD EEMASON PARKWAY LIN, IN 46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0842 SS=D Bldg. 00	DON (Director of N and post dialysis ass Resident 54's clinical should have been or clinical record.  On 11/18/22 at 11:3 copy of the Nursing October 2019, and i policy in use by the indicated the provis of practice for residitreatment included, the resident's conditional complications before treatments."  3.1-37(a)  483.20(f)(5), 483.7 Resident Records §483.20(f)(5) Resident Records is resident-identifiable accordance with a agent agrees not to information exceptitiself is permitted to \$483.70(i) Medica §483.70(i) Medica §483.70(i) (1) In accordessional standards.	Jursing) indicated that some presessments were missing from all record. The assessments ompleted and recorded in the sompleted and recorded in the seesaw		IAU			DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED  B. WING 11/21/2022				
		155593	B. WING		11/21/2022		
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD			
INDIANA	MASONIC HOME	HEALTH CENTER	800 FREEMASON PARKWAY FRANKLIN, IN 46131				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	§483.70(i)(2) The confidential all inforesident's records regardless of the fithe records, excep (i) To the individual representative where the records, excep (ii) Required by La (iii) Required by La (iii) For treatment, operations, as per compliance with 4 (iv) For public hear abuse, neglect, or oversight activities proceedings, law organ donation pure or to coroners, medirectors, and to a health or safety as compliance with 4 §483.70(i)(3) The medical record information destruction, or una §483.70(i)(4) Mediretained for- (i) The period of till (ii) Five years from when there is no recontain- (iii) For a minor, 3 reaches legal age	facility must keep promation contained in the form or storage method of out when release isal, or their resident ere permitted by applicable aw; payment, or health care mitted by and in 5 CFR 164.506; alth activities, reporting of a domestic violence, health activities, research purposes, irposes, research purposes, edical examiners, funeral evert a serious threat to a permitted by and in 5 CFR 164.512.  facility must safeguard formation against loss, authorized use.  ical records must be me required by State law; or in the date of discharge requirement in State law; or years after a resident					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DA	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> COM	IPLETED	
155593 B. WING 11/2	21/2022	
STREET ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER  800 FREEMASON PARKWAY		
INDIANA MASONIC HOME HEALTH CENTER FRANKLIN, IN 46131		
<b></b>	(7/5)	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFRENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
(iii) The comprehensive plan of care and	DATE	
services provided;		
(iv) The results of any preadmission		
screening and resident review evaluations and		
determinations conducted by the State;		
(v) Physician's, nurse's, and other licensed		
professional's progress notes; and		
(vi) Laboratory, radiology and other diagnostic		
services reports as required under §483.50.		
Based on observation, interview, and record F 0842 F842 Resident Records –	12/19/2022	
review, the facility failed to ensure the clinical Identifiable Information		
record was accurate for 1 of 2 residents reviewed (Brace/Splint Documentation)		
for positioning devices. An arm brace and edema  1. Corrective action for the		
glove were documented as applied and were affected resident: The brace order		
unavailable. (Resident 246) for resident #246 was placed on		
hold temporarily and then		
Findings include:  discontinued while therapy clarifies the need for a brace for		
On 11/15/22 at 12:13 p.m., Resident 246 was resident #246.		
observed resting in his recliner. Resident 246's  2. Corrective action for		
left arm was resting across his chest and no brace residents that have the potential to		
or edema glove were visible on the left arm.		
order for a brace or splint have the		
On 11/16/22 at 10:38 a.m., Resident 246 was potential to be affected. An order		
observed resting in his recliner. Resident 246's review was completed to identify		
left arm was resting across his chest and no brace all residents in the facility with an		
or edema glove were visible on the left arm. order for a brace or splint. For		
those residents identified, an audit		
On 11/17/22 at 10:30 a.m., Resident 246 was was completed to ensure that the		
observed resting in his recliner. Resident 246's brace or splint is available for use		
left arm was resting across his chest and no brace on the resident (See Attachment:		
or edema glove were visible on the left arm.  Brace/Splint Initial Audit). The		
documentation related to the		
On 11/17/22 at 2:10 p.m., Resident 246 was brace or splint use for each observed resting in his recliner. Resident 246's identified resident was reviewed for		
left arm was resting across his chest and no brace accuracy (See Attachment: or edema glove were visible on the left arm.  Brace/Splint Audit)		
3. Measures to prevent future		
On 11/17/22 at 3:30 p.m., Resident 246 was deficient practice: The Admission		
observed resting in bed. Resident 246's left arm  Chart Review form (See		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	00	COMPL	ETED
		155593	B. W	ING		11/21/	2022
					LANDERS OF THE STATE OF THE STA		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
INIDIANIA		LIEAL TH OFNITED			EEMASON PARKWAY		
INDIANA	MASONIC HOME	HEALTH CENTER		FRANK	LIN, IN 46131		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	was resting across l	nis chest and no brace or			Attachment: Admission Chart		
	edema glove were v	visible on the left arm.			Review) has been updated to		
					include checking for brace or		
	Resident 246's clini	cal record was reviewed on			splint orders and if the brace of	or	
	11/17/22 at 1:56 p.1	m. The diagnoses included, but			splint is present for use on the	;	
	were not limited to,	, nontraumatic intracerebral			resident. If the ordered brace	or	
	hemorrhage in brain	n stem (stroke) and hemiplegia			splint is not available, the		
	(muscle weakness of	or partial paralysis on one side			physician will be notified for		
	of the body that car	affect the arms, legs, and			clarification of need versus		
	facial muscles) affe	ecting left nondominant side			obtaining the appropriate devi	ce for	
	(left side).				the resident. A Brace/Splint A	udit	
					(See Attachment: Brace/Splin	t	
	Progress notes, dated 11/10/22 at 5:38 p.m.,				Audit) has been implemented	for	
	indicated Resident	246 was cognitively intact and			documentation of auditing of		
	had a stroke that aft	fected his left side.			brace/splint use. Audits will be	)	
					conducted twice weekly for 3		
	A Physician order a	and the associated Treatment			months. If 100% compliance is	S	
	Administration Rec	cord (TAR) document indicated			achieved, auditing will then be	)	
	"left elbow extension	on brace on in am and			reduced to weekly for 3 addition	onal	
	encourage to wear	8 hours daily, edema glove to			months. If 100% compliance is	S	
		after 8 hours of wear. Check			then achieved, auditing will be	;	
	skin underneath eve	ery day and evening. Start date			discontinued. Auditing will be	for	
		date from 11/17/22 to 12/1/22."			residents with a brace or splin	t	
		cated nursing staff initialed the			order to ensure the device is		
		e brace and glove were applied			present, and documentation o	f use	
		kin checks were performed as			or non-use is accurate. Facilit	-	
	directed by the phys	sician's order for the following			nurses will be provided educa	tion	
	dates and times:				on brace and splint order follo		
					through and accuracy of relate		
	11/11/22 - day shift	t and evening shift			documentation (See Attachme		
					Annual Survey Plan of Correc	tion	
	11/12/22 - day shift	and evening shift			Nurse Education and POC		
					Training Report).		
	11/14/22 - day shift	and evening shift			<ol> <li>Monitoring of corrective</li> </ol>		
					actions: Corrective actions an		
	11/15/22 - day shift	and evening shift			auditing will be discussed in the		
					facility Quality Assurance and		
	11/16/22 - day shift	and evening shift			Performance Improvement me	-	
					monthly for the next 6 months		
	11/17/22 - day shift	t					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> B. WING		COMPLETED 11/21/2022		
155593					1 1/2 1/2022		
NAME OF I	PROVIDER OR SUPPLIEF	8		ADDRESS, CITY, STATE, ZIP COD			
INDIANA MASONIC HOME HEALTH CENTER			800 FREEMASON PARKWAY FRANKLIN, IN 46131				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE		
	A Physician order a	and the associated Treatment					
	1	ord (TAR) document					
	indicated, "Fully di	sengage brace to left arm					
	before applying or removing, do not slide on/off						
	1 -	ate 11/10/22 and hold date from					
		"." The document indicated					
		ed the record indicating the					
		ed as ordered by the llowing dates and times:					
	physician for the fo	nowing dates and times.					
	11/10/22 - night shift						
	11/11/22 - day shift, evening shift, and night shift						
	11/12/22 - day shift, evening shift, and night shift						
	11/13/22 - day shift and night shift						
	11/14/22 - day shift, evening shift, and night shift						
	11/15/22 - day shift, evening shift, and night shift						
	11/16/22 - day shift, evening shift, and night shift						
	11/17/22 - day shift						
	On 11/21/22 at 10:30 a.m., the DNS provided a						
	copy of the Resident Inventory Sheet, dated						
		ated it was the current					
		Resident 246. A review of the					
		ned by Resident 246's family 2, included clothing,					
		, toiletries, and electronics.					
	The inventory sheet did not include the left elbow						
	brace or edema glov						
	During an interview on 11/18/22 at 2:10 p.m., Resident 246 indicated he has not worn the left						
elbow brace or edema glove since his admission		1					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155593	B. WING			11/21/2022	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD	•	
INDIANA MASONIC HOME HEALTH CENTER					LIN, IN 46131		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECT			
PREFIX	`	CY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	into this facility nor	were the items in the facility.					
	During an interview on 11/18/22 at 2:20 p.m., CNA (Certified Nursing Assistant) 2 indicated she had taken care of Resident 246 "most of the time"						
		and she had never seen the					
		na glove in his room nor on his					
	person.						
	During an interview on 11/18/22 at 4:11 p.m., DNS						
	indicated Resident 246 was admitted with a						
	physician's order to wear a left elbow brace and						
	edema glove on a daily basis. Resident 246's left elbow brace and edema glove were not sent from						
		_					
	the previous facility and so they were not available. The DNS was unsure why the TAR						
	documents indicated the brace and edema glove						
	were signed off indicating they were applied and						
	subsequently removed. The items were not in the						
	building and could	not have been applied to the					
	resident.						
	(Licensed Practical admission, Resident elbow brace and ed- hours daily. Reside	v on 11/21/22 at 10:20 a.m., LPN Nurse) 4 indicated at t 246 had an order for the left ema glove to be worn for 8 ent 246 was not able to wear were not available in the					
	facility.						
	DNS indicated the finursing documentate	y on 11/21/22 at 10:25 a.m., the facility did not have a specific tion policy. The DNS principle of good nursing to be "accurate".					
	Nurses Association Documentation: Gu	5 p.m., a review of the American - Principles for Nursing uidance for Registered Nurses, ed, "Nursing Documentation					

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

PRINTED: 01/03/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155593	B. WING			11/21/2022	
NAME OF PROVIDER OR SUPPLIER INDIANA MASONIC HOME HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 800 FREEMASON PARKWAY FRANKLIN, IN 46131				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)		DATE
	Principles: Principle 1. Documentation						
	CharacteristicsaccuratecompletePrinciple 5.						
	Documentation Ent	riesaccurate, valid and					
	complete"						
	3.1-50(a)(2)						

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