STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: November 1, 2, 3, 6, and 8, 2023 Facility number: 001133 Provider number: 155593 AIM number: 200090430 Census Bed Type: SNF/NF: 144 SNF: 2 Total:146 Census Payor Type: Medicare: 13 Medicaid: 74 Other: 59 Total: 146 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 13, 2023.	F 0000	Indiana Masonic Home Credible Allegation of Compliance The submission of this plan of correction does not indicate an admission by the Indiana Masonic Home, Inc (the "facility") that the findings and allegation contained herein are an accurate and true representation of the quality of care and services provided to the residents of the Indiana Masonic Home, Inc. This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all State and Federal requirements governing the management of this facility. It is thus submitted as a matter of stature only.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

William Pierce | Administrator | 11/22/2023

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 continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure potentially hazardous materials were kept secure behind locked doors to prevent resident's access to the materials for 1 of 5 observations. (Electrical Closet) Finding includes: On 11/2/23 at 1:00 p.m., the following was observed on the second floor of the facility: A room labeled "Electrical Closet", located near the dining area and the Scottish Rite resident hallways for rooms 2104 through 2142, was ajar. The door handle was in the locked position but the door itself was not closed or latched completely and could be pushed open easily. Inside were multiple electrical panels with warning labels reading "Shock and Arc Flash Hazard". No staff were visible in the immediate area. During an interview on 11/2/23 at 1:05 p.m., the Director of Nursing (DON) indicated that the "Electrical Closet" room door should be kept locked and latched completely. During an interview on 11/2/23 at 2:26 p.m., the DON indicated that the Scottish Rite unit had 8 of 40 residents who were cognitively impaired and independently mobile who could have had access to the opened "Electrical Closet" room. On 11/3/23 at 12:55 p.m., the DON provided a copy of a policy, dated 12/2/21, titled, "Electrical Safety", and indicated it was the policy currently	F 0689	1. No residents were found to be affected by the deficient practice. 2. All facility residents have the potential to be affected by the deficient practice due to the location of the door in a common area. 3. All electrical hazard doors have been inspected and adjusted as needed to ensure they close and latch properly. Maintenance department staff, who have access to the electrical (hazard) rooms were in-serviced to the existing Electrical Safety Policy (see ***Attachment A***, and in-service signature form see ***Attachment B***) on November 21, 2023. 4. The maintenance department has developed an audit tool, completed for the week of 11/14/23 and 11/21/23 (see ***Attachment C***) for weekly inspections of electrical hazard doors. The weekly inspections will identify any door that does not close and latch properly. Any issue with a door will be repaired immediately. The weekly audit will continue ongoing. Results of the audits for the next 6 months will be reported to the Administrator for QAPI team review and discussion.	11/21/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	in use by the facility. A review of the policy indicated, " ...Breaker cabinets shall be locked at all times that are accessible to general staff or residents/patients. Secure rooms where equipment is located when unattended." 3.1-45(a)(1)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure the daily posted nurse staffing reflected the actual hours worked by staff and failed to ensure the post was easily accessible for staff and guests for 3 of 5 days during the survey period. Findings include: During an observation on 11/2/23 at 10:30 a.m., the posted daily staffing document was observed to lack the actual hours worked by staff. The document was observed to be posted behind the receptionist desk hanging on the wall approximately 6 feet from the visitor side of the receptionist desk and was difficult to read due to the small size print. On 11/3/23 at 9:30 a.m., the posted daily staffing document was observed to lack the actual hours worked by staff. The document was observed to be posted behind the receptionist desk hanging on the wall approximately 6 feet from the visitor side of the receptionist desk and was difficult to read due to the small size print. On 11/4/23 at 8:33 a.m., the posted daily staffing document was observed to lack the actual hours worked by staff. The document was observed to be posted behind the receptionist desk hanging on the wall approximately 6 feet from the visitor side of the receptionist desk and was difficult to	F 0732	1. The facility believes the requirement for this finding was met originally, but the CMS guidance was interpreted differently by the IDOH team. The facility does not wish to dispute the finding due to the CMS guidance leaving room for interpretation to how the shift is designated and opinion of a prominent displayed location. And out of respect for the IDOH survey team interpreting the CMS guidance. No residents were found to be affected by the deficient practice. 2. No facility residents were found to be affected by this finding and not believed to have been affected by this finding. 3. The original daily nursing staff documentation form identified the shifts as day, evening, and night, which in healthcare is a common shift designation. The daily staff posting form that includes the required reporting data, was amended during the IDOH annual survey to include the shift hours in addition to the previous designation (see ***Attachment D***). The display location for the	11/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	read due to the small size print. On 11/2/23 at 11:33 a.m., the Director of Nursing, provided the posted daily staffing for October 2023. A review of the posted daily staffing documents, dated October 1 through October 31, 2023, indicated no actual staffing hours were documented on the postings. During an interview on 11/3/23 at 1:30 p.m., the DON (Director of Nursing) indicated she was unsure if the facility policy indicated if the actual hours worked should have been posted on the daily staffing postings. On 11/3/23 at 9:57 a.m., the DON provided a facility policy titled, Facility Required Postings and indicated it was the current policy being used by the facility. A review of the policy indicated "The facility will post required postings in an area that is accessible to all staff and residents"		posting was also relocated to a wall mounted frame, outside the staffing coordinator office in the main entry facility lobby. This location is centrally located and the daily staff posting can be easily viewed. 4. The staffing coordinator will complete the daily nursing staff posting and monitor that the data posting form used includes the shift designation by hours and day-evening-night, and continues to be posted in a prominent location daily.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was served in a sanitary manner for 2 of 3 kitchen observations. Staff hair was not covered while in the kitchen. (Kitchen Staff 2, Kitchen Staff 3, Kitchen Staff 4, Cook 5, Kitchen Staff 6) Findings include: 1. During the initial kitchen observation on 11/1/23 from 11:00 a.m. to 11:30 a.m., the following was observed: - Kitchen Staff 2 was observed walking throughout the kitchen area and preparing the noon meal trays near the steam table where the noon meal was being held. Kitchen Staff 2 was observed to have multiple loose hairs, approximately 10 inches in length, in front of both ears. The loose hairs were observed to not be covered. - Kitchen Staff 3 was observed walking throughout the kitchen area and preparing the noon meal trays near the steam table where the noon meal was being held. Kitchen Staff 3 was observed to have multiple loose hairs, approximately 6 inches in length, in front of both ears. The loose hairs were observed to not be covered. - Kitchen Staff 4 was observed walking	F 0812	1. No residents were found to be affected by the deficient practice. 2. All facility residents have the potential to be affected by the deficient practice due to portions of meal preparation taking place in the main kitchen. The deficient practice was not observed in the prep-serving kitchens located at the skilled nursing center dining rooms. 3. All dietary staff have been in-serviced (see ***Attachment F***) for the facility hairnet policy and expectation of compliance (see ***Attachment E***). Inservice was conducted by the contracted Registered Dietician and department leadership. 4. The Dietary manager for 6 months will audit by observation (see ***Attachment G***) dietary staff hairnet compliance weekly for 3 months and monthly for 3 months. The Dietary Manager will report findings of hairnet utilization compliance audit and monitoring, to the monthly QAPI (see ***Attachment H***) team for review and discussion. Instances of dietary staff found non-compliant with the hairnet policy will receive additional education on the facility	11/23/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	throughout the kitchen area near the steam table where the noon meal was being held. Kitchen Staff 4 was observed to have multiple loose hairs, approximately 10 inches in length, in front of both ears. The loose hairs were observed to not be covered. - Cook 5 was observed at the steam table plating the noon meal. Cook 5 was observed to have multiple loose hairs, approximately 2 inches in length, at the neckline and in front of both ears. The loose hairs were observed to not be covered. 2. During a follow up kitchen observation 11/1/23 from 12:40 p.m. to 1:00 p.m., the following was observed: - Kitchen Staff 3 was observed walking throughout the kitchen area and preparing the noon meal trays near the steam table where the noon meal was being held. Kitchen Staff 3 was observed to have multiple loose hairs, approximately 6 inches in length, in front of both ears. The loose hairs were observed to not be covered. - Cook 5 was observed at the steam table plating the noon meal. Cook 5 was observed to have multiple loose hairs, approximately 2 inches in length, at the neckline and in front of both ears. The loose hairs were observed to not be covered. - Kitchen Staff 6 was observed restocking clean plates at the steam table. Kitchen Staff 6 was observed to have multiple loose hairs, approximately 3 inches in length, across the forehead area. The loose hairs were observed to not be covered. During an interview on 11/1/23 at 11:45 a.m., the		policy and repeat violations will be addressed through the disciplinary process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING 00 B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMPASS PARK	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Director of Dining Services indicated staff hair was to be covered while in the kitchen. On 11/2/23 at 8:30 a.m., the Dietary Manager provided a copy of the Orientation and Education - Uniform Dress Code policy, dated June 2018, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...personal cleanliness and neat appearance are essential for food service worker...wear the approved hair restraint when on duty...cover all hair..." On 11/8/23 at 2:00 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints such as...hair coverings or nets...that are designed and worn to...effectively keep their hair from contacting...exposed food..." 3.1-21(i)(2) 3.1-21(i)(3)			