

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

PRINTED: 05/14/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185177</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/02/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GRAYSON MANOR NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754</b>
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(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
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>A standard health survey was initiated on 04/30/13 and concluded on 05/02/13 and a Life Safety Code survey was initiated on 04/30/13 and concluded on 05/01/13 with deficiencies cited at the highest scope and severity of an "F", with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p><b>F 166 SS=D</b> 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure grievances were reported, investigated, and efforts to resolve concerns were done promptly for one (1) of fifteen (15) sampled residents (Resident #1) and one (1) unsampled resident (Unsampled Resident A). The facility failed to follow the grievance process related to reporting, investigating, following up and include reports to the Quality Assurance program, resulting in the resident having to take bed baths with cold water for approximately six (6) months after Resident #1 had reported multiple times to multiple staff a concern with cold water in the bathroom. In addition, the facility failed to follow the grievance policy related to reporting, and following up with the complainant with action taken after the family</p>	F 000	<p><b>PLAN OF CORRECTION GRAYSON MANOR NURSING HOME SURVEY COMPLETION DATE OF May 01, 2013</b></p> <p><b>F166</b></p> <p>On May 1, 2013 the Director of Nurses instructed all care givers and left a voice mail to all Nurses' concerning the need to carry a covered wash basin of warm water from the clean utility room at West 1 Nurses' Station for bathing resident #1. This was to be done until water temperature in resident #1's bathroom was resolved. On May 1, 2013 a licensed plumber from Al's Plumbing Company was contacted concerning the water temperature in room 39. The licensed plumber came to the facility on May 2, 2013 and inspected the plumbing in room 39. The problem was found and parts were ordered. On May 6, 2013 the licensed plumber returned to the facility and replaced the valve in the bathroom of room 39. On May 3, 2013 Social Services Director and LPN #1 was counseled by the Director of Nursing and Personnel Director regarding the importance of following the grievance policy and filing a grievance report upon receiving a complaint.</p>	6/15/2013
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

*Joseph R. Vance*

*Administrator*

*May 17, 2013*

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

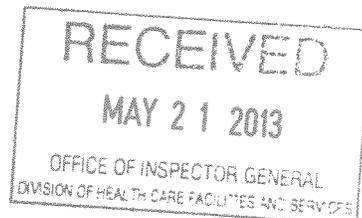
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F 166	<p>Continued From page 1 of Unsampld Resident #A had voiced a complaint regarding a concern with medication administration</p> <p>Refer to F246</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Abuse Prevention Filing and Investigation of a Grievance Policy and Procedure, revised 07/21/10, revealed a grievance may be submitted orally or in writing. If a nursing staff member received a grievance it was their responsibility to see that a grievance form Appendix B was started and an initial investigation was instituted. The written Grievance form is turned over to the Social Services Director and a copy is given to the Department Director of the department involved in the grievance. A written report of the findings would be given to the Administrator within five (5) working days. The person filing the grievance would be informed of the findings and action taken within ten (10) working days of the filing of the report. All written grievances would be maintained on a grievance log kept by the Social Service Director. The Grievance Log would be reviewed at least quarterly as part of the Quality Assurance Program.</p> <p>1. Observation, on 04/30/13 at 9:00 AM, during water temperature checks of the facility found the sink water temperature for room 39 ( sampled Resident #1) was 88 degrees.</p> <p>Interview, on 04/30/13 at 9:10 AM, with Certified Nursing Assistant (CNA) #1 revealed she had reported verbally to maintenance that some of the</p>	F 166	<p>On May 1, 2013 all residents' rooms were audited by the Maintenance Director to ascertain that all water temperatures were maintained between guidelines. All Nursing Facility residents will be interviewed by the Social Services Director by May 20, 2013 to ensure there are no other grievances that have not been addressed.</p> <p>On May 15, 2013 all staff was in-serviced by the Maintenance Director regarding the proper water temperatures in residents' rooms. Staff was also in-serviced on the importance of notifying and the procedure for notifying the Maintenance Department when the water temperature in a resident room is not maintained between guidelines. All staff was in-serviced on May 15, 2013 by the Staff Development Coordinator on the grievance policy related to reporting, investigating and following up of grievances.</p> <p>An audit conducted by the Maintenance Director related to water temperatures maintained between guidelines has been completed. The audits will be completed daily for three weeks if 100% compliance is maintained, audits then will be completed weekly. This audit will be conducted as part of the facility's Quality Assurance Program. An audit conducted by the Staff Development Coordinator related to grievances has been completed.</p>		



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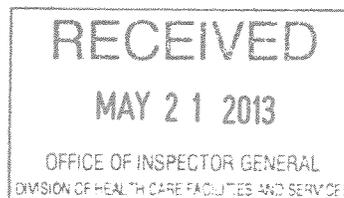
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F 166	<p>Continued From page 2</p> <p>rooms did not have hot water including room 39.</p> <p>Observation, on 05/01/13 at 10:15 AM, revealed the water in room 39 remained running for 15 minutes, with the water temperature checked by the Maintenance Director #5 and found to be 90 degrees.</p> <p>Review of the medical record for Resident #1 revealed the facility admitted the resident on 02/28/11. Current diagnoses included: Neoplasm of the Respiratory System; Palliative Care; and Depression. A Significant Change Minimum Data Set (MDS) assessment completed, on 07/31/12, revealed the facility assessed the resident's Basic Interview for Mental Status (BIMS) score at 15 as cognitively intact. A Significant Change (MDS) assessment completed, on 12/18/12, revealed the facility assessed the resident's BIMS score at 15 again. Review of the Quarterly (MDS) assessment completed on 03/07/13 revealed the facility assessed the resident's BIMS score at 12 as moderately impaired.</p> <p>Interview, on 04/30/13 at 9:10 AM, with Resident #1 revealed he/she stated they had complained about the cold water multiple times and he/she was told by the facility staff they could not help it.</p> <p>Interview with Certified Nursing Assistant (CNA) #4, on 05/02/13 at 7:55 AM, revealed her statement that maintenance knew about the hot water problems and it had been an issue for a long time.</p> <p>Interview with the Social Worker, on 05/02/13 at 8:40 AM, revealed she had been in her current position about 2 years. She stated she had not</p>	F 166	<p>The audits will be completed weekly for 4 weeks, then monthly until 100% compliance is achieved and then quarterly. This audit will be conducted as part of the facilities Quality Assurance program.</p>	
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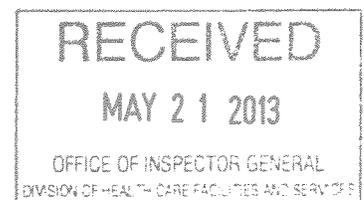
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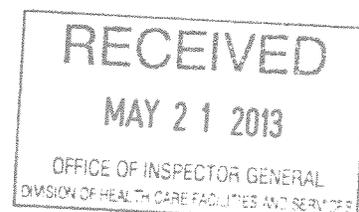
F 166	Continued From page 3 received a grievance about anything for Resident #1. She stated she was not aware of any concerns about hot water in room 39. She stated if she had received a complaint from Resident #1 about hot water, she would not have considered that a grievance but would have written a work order for maintenance.  Interview with CNA #4 and Licensed Practical Nurse (LPN) #4, on 05/02/13 at 9:30 AM, revealed they had never completed a grievance form for any complaints. They stated they had complaints about laundry issues and loud television, but they just take it to the source and try to resolve the issue.  Interview, on 05/02/13 at 10:30 AM, with Resident #1 revealed he/she stated it was reported to all three (3) maintenance men ever since he/she had been at the facility. He/she stated he/she stopped getting showers about six (6) months ago due his/her condition. The resident stated he/she had requested to change rooms as well but was told there were no rooms available.  2. Interview during the group meeting, on 04/30/13 at 1:30 PM, revealed the family of Unsampled Resident A voiced a concern to the Ombudsman around April 15-19 that was reported to the Social Worker at that time. The Ombudsman reported the family reported Unsampled Resident A received an antibiotic that made the resident sick, even after she had told them not to give it to the resident.  Interview, on 05/02/13 at 8:40 AM, with the Social Worker revealed the last grievance completed was on 01/22/13. She stated she did get a	F 166		
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F 166	<p>Continued From page 4</p> <p>concern from the Ombudsman around April 15-19 regarding Unsampled Resident A by the family. The concern was that the resident had received an antibiotic that made her sick. She stated she had spoken with the family and the Director of Nursing, but not the Administrator. She stated she did not complete a grievance form.</p> <p>Interview, on 05/02/13 at 10:30 AM, with Unsampled Resident A's family revealed they had received a call, on 04/10/13, about their family member throwing up two (2) times. The family stated they had taken the resident to the Surgeon on the same day, for a follow up appointment, after Gallbladder surgery. They stated when the resident returned they told the facility the Surgeon said the resident did not need to be treated for an infection, and to not give the resident the antibiotic prescribed as it made the resident vomit. The family stated the facility gave the antibiotic again, on 04/11/13, even though they told the staff not to, and the resident got sick again.</p> <p>Review of the nurses notes for Unsampled Resident A revealed, on 04/10/13, Licensed Practical Nurses (LPN) #1 documented at 2:30 PM the culture was colonized and the resident did not need to be treated, as they would heal with a topical treatment. The note continued on with, the family stated the Physician was going to talk with the resident's primary care physician. Continued review of the nurses notes revealed the facility received an order, on 04/11/13 at 1:00 PM, to discontinue the antibiotic.</p> <p>Interview, on 05/02/13 at 9:45 AM, with the Director of Nursing (DON) revealed she was</p>	F 166			



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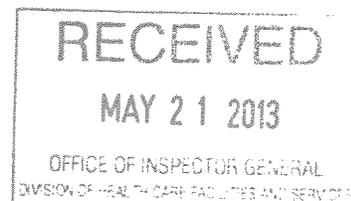
F 166 : Continued From page 5

aware of the concern with Unsampld Resident A and the antibiotic. She stated the family was upset about the the resident getting sick, but the facility was unsure if it was the antibiotic because there was a virus going around at the time. She stated the family told the staff they were going to call the Physician to get the antibiotic stopped. The DON stated the antibiotic was given, on 04/11/13, because they had not received an order to discontinue the medication. She stated a grievance was not completed for this incident, but should have been for tracking and trending purposes.

Interview, on 05/02/13 at 9:55 AM, with LPN #1, revealed she had talked with the family of Unsampld Resident A, as stated in the nurses notes. She stated the facility did not receive an order to discontinue the antibiotic. She stated the resident did receive the antibiotic, on 04/11/13, because it was not discontinued. She stated the family told her the surgeon was going to call the primary care physician to discuss cancelling the antibiotic. She stated the facility called the primary care physician, on 04/11/13, and received an order to discontinue the antibiotic. She stated she did not complete a grievance but should have. She stated she had been trained on completing grievances and they were used for issues like this.

Interview, on 05/02/13 at 1:05 PM, with the Administrator revealed Social Services was responsible for overseeing the grievance process. He stated anyone could complete a grievance. He stated it was important to have a grievance process system to monitor concerns, and it was included in the Quarterly Quality Assurance

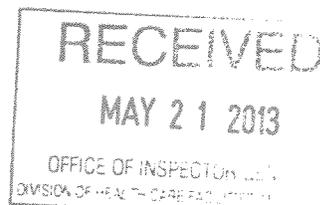
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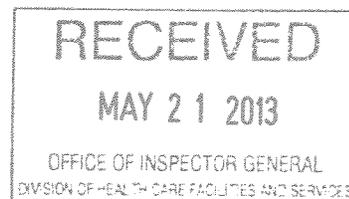
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F 166	Continued From page 6 meeting. He stated he was not aware of any concerns with cold water in room 39. He stated the Ombudsman and the DON had been in communication with him, regarding the concern with Unsampled Resident A.	F 166		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility's policy, it was determined the facility failed to provide hot water for bathing, for one (1) of fifteen (15) sampled residents (Resident #1). The facility failed to respond to Resident #1 when they voiced concerns to facility staff regarding cold water for bathing.  Refer to Tag F166  The findings include:  Review of the facility's policy regarding Accommodation of Needs, undated, revealed at all times it was the goal to ensure the resident	F 246	<b>F246</b>  On May 1, 2013 the Director of Nurses instructed all care givers and left a voice mail to all Nurses' concerning the need to carry a covered wash basin of warm water from the clean utility room at West I Nurses' Station for bathing resident #1. This was to be done until water temperature in resident #1's bathroom was resolved. On May 1, 2013 a licensed plumber from Al's Plumbing Company was contacted concerning the water temperature in room 39. The licensed plumber came to the facility on May 2, 2013 and inspected the plumbing in room 39. The problem was found and parts were ordered. On May 6, 2013 the licensed plumber returned to the facility and replaced the valve in the bathroom of room 39.  On May 1, 2013 all residents' rooms were audited by the Maintenance Director to ascertain that all water temperatures were maintained between guidelines.  On May 15, 2013 all staff was in-serviced by the Maintenance Director regarding the	6/15/2013



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F 246	<p>Continued From page 7 was satisfied and that all of their needs were met.</p> <p>Review of the Weekly Temperature Checks log, from 01/2012 until 04/29/13, revealed room hot water temperatures were checked weekly of one random room of the Skilled Nursing Wing, the Personal Care Wing, Rooms 62 and 64 and rooms 34-38. Room 39 was on the hallway of 34-38. Some temperatures had the room numbers written out to the the side, but not all temperatures indicated what room was checked. Of the temperatures with room numbers, none had room 39.</p> <p>Observation, on 04/30/13 at 9:00 AM, during water temperature checks of the facility, found the sink water temperature for room 39 (Resident #1) was 88 degrees. A check of Room 38 found the temperature was 102 degrees. Room 37's water temperature was found to be 102 degrees. A check of Room 34 found the temperature was 108 degrees. Rooms 38, 37 and 34 were on the same hall as 39. A check of five (5) other rooms, 28, 42, 45, 50, 54 and the shower room found the temperatures within range of 100 degrees and 110 degrees.</p> <p>Interview, on 04/30/13 at 9:10 AM, with Resident #1 revealed he/she stated they had complained about the cold water multiple times and he/she was told by the facility they could not help it</p> <p>Interview, on 04/30/13 at 9:10 AM, with Certified Nursing Assistant (CNA) #1 revealed she had reported verbally to maintenance of some of the rooms not having hot water including room 39.</p> <p>Interview with CNA #2, on 05/01/13 at 9:55 AM,</p>	F 246	<p>proper water temperatures in residents' rooms. Staff was also in-serviced on the importance of notifying and the proper procedures for notifying the Maintenance Department when the water temperature in a resident room is not maintained between guidelines.</p> <p>An audit conducted by the Maintenance Director related to water temperatures maintained between guidelines has been completed. The audits will be completed daily for three weeks if 100% compliance is maintained, audits then will be completed weekly. This audit will be conducted as part of the facility's Quality Assurance Program.</p>		



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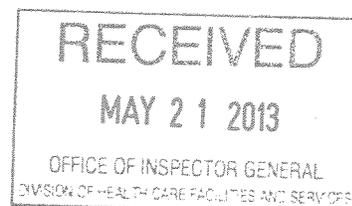
F 246	<p>Continued From page 8</p> <p>revealed she had not reported to anyone about cold water in room 39 but was sure maintenance knew about it. She stated there was other rooms on the hallway that did not have hot water. She stated she would sometimes go to another room to get hot water to give Resident #1 a bath. She stated she had used the cold water to give Resident #1 a bath, and just told the resident it was cold and the resident would reply he/she knows.</p> <p>Interview with Resident #1, on 05/01/13 at 10:00 AM, revealed he/she had been in the same room about 2 years and didn't believe the water had ever been hot.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 05/01/13 at 10:05 AM, revealed she had talked to Maintenance about some of the rooms not having hot water, and believed they had worked on the water heater, but it did not help. She stated she had not received a complaint from Resident #1. She stated it was not acceptable for the residents to have to use cold water to get cleaned up, as it was not comfortable and could make them sick.</p> <p>Observation, on 05/01/13 at 10:15 AM, revealed the water in room 39 remained running for 15 minutes, with the water temperature checked by Maintenance Director #5 found to be 90 degrees. The Maintenance Director #5 proceeded to check the water heater on the hall, and stated it was not kicking in and must be broken.</p> <p>Interview with the Maintenance Director #5, on 05/01/13 at 10:15 AM, revealed he had not received a work order for room 39 regarding the</p>	F 246		
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NAME OF PROVIDER OR SUPPLIER  <b>GRAYSON MANOR NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>605 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754</b>	
(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 246	Continued From page 9 cold water. He stated the Resident in room 39 complained on 04/30/13, and he and the Administrator checked the water temperature, and found it to be 102 degrees. He stated he failed to document this anywhere. On review of the water temperature log, he stated they just do random water temperatures, and don't have a system to ensure all rooms are checked periodically.  Interview with the Administrator, on 05/01/13 at 10:30 AM, revealed he had checked the water temperatures with the Maintenance Director, on 04/30/13, and it was not room 39, but was rooms 35 and 38. He stated this was the first concern he heard about the cold water in room 39.  Interview with Resident #1, on 05/01/13 at 10:00 AM, revealed he/she had reported to all three (3) Maintenance men since they had been at the facility. He/she stated he/she stopped getting showers about six (6) months ago, due to his/her condition. The resident stated he/she had requested to change rooms as well, but was told there were no rooms available.  Interview with CNA #4, on 05/02/13 at 7:55 AM, revealed that Maintenance knew about the hot water problems, and that it had been an issue for a long time. She stated she did not fill out a work order, but everybody talked about problems with the hot water.	F 246		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial	F 250	F250  On May 3, 2013 Social Services Director was counseled by the Director of Nursing regarding the need to document in a	6/15/2013



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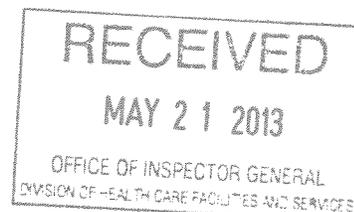
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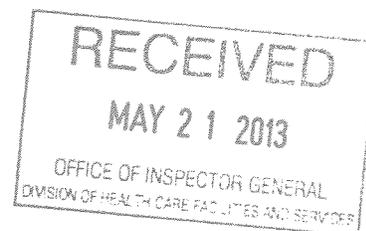
F 250	<p>Continued From page 10 well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review it was determined the facility failed to ensure residents received services for vision care for one (1) of fifteen (15) sampled residents, (Resident #10). The facility failed to intervene when Resident #10's glasses were broken and taped up for at least 6 months.</p> <p>The findings include:</p> <p>Observation, on 04/30/13 during initial tour, found Resident #10 sitting up in the bed. The resident was wearing glasses that were broken and taped up on the top left lens.</p> <p>Interview with Resident #10, on 04/30/13 at 8:40 AM, revealed the resident stated the glasses had been broken for "a long time". The resident stated he/she had talked to Social Services about the broken glasses, but had not heard anything back.</p> <p>Review of the clinical record for Resident #10 revealed the facility admitted the resident, on 10/13/10, with diagnoses of Anemia, Chronic Obstructive Pulmonary Disease, Anxiety, Diabetes Type II, Morbid Obesity, Hypertension, Hyperlipidemia, and Chest Pain. Review of a Significant Change Minimum Data Set (MDS) assessment completed, on 01/23/13, revealed the facility assessed the resident's BIMS at 15, or cognitively intact. The Quarterly MDS</p>	F 250	<p>resident's medical chart pertinent information related to resident needs. The Ward Clerk at Skilled One Nurses Station made an appointment for resident #10 with Doctor Abney (Optometrist) for May 20, 2013.</p> <p>On May 17, 2013 the Ward Clerk/CMA observed all residents who wear glasses to ensure the glasses did not need to be repaired or replaced.</p> <p>All staff was in-serviced on May 15, 2013 by the Staff Development Coordinator on the proper procedures for notification to the Social Services Director, if a resident needs glasses repaired or replaced. Also the Staff Development Coordinator stress to all staff the importance of being more aware of residents needs being met in a timely manner.</p> <p>An audit conducted by the Ward Clerk/CMA was completed. The audits will be completed monthly. If any resident's glasses are observed needing repaired or replaced the Optometrist will be contacted and the resident will be scheduled an appointment at that time. This audit will be completed as part of the facility's Quality Assurance Program.</p>	
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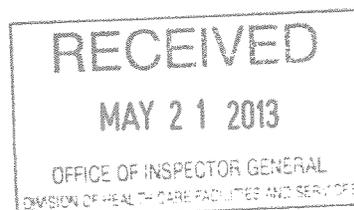
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F 250	Continued From page 11 assessment, completed 04/15/13, revealed the facility assessed the resident's BIMS at 13, or cognitively intact.  Interview with the Ombudsman during the group meeting, on 04/30/13 at 1:30 PM, revealed Resident #10's glasses had been broken since about November 2012.  Interview with Certified Nursing Assistant (CNA) #3, on 05/02/13 at 8:10 AM, who was responsible for making the appointment/list for eye exams, revealed the facility had a Optometrist who came to the facility once a month. She stated Resident #10 was on the list for September 2012, but was in the hospital. She stated the resident did not get put back on the list, but should have been.  Interview with the Social Services Department, on 05/02/13 at 8:20 AM, revealed she had sent an application to the Lyons Club, on behalf of Resident #10, for vision/glasses financial assistance in March 2013, but had not received a response. She was unable to produce evidence of the form or contact with the Lyons Club and acknowledged she did not document in the progress notes that a request had been sent for Resident #10.	F 250		
F 441 SS=F	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	F 441	F441  On May 3, 2013 Laundry Supervisor and Laundry Aides were counseled by the Director of Nursing regarding the necessity of keeping the residents clothing delivery cart covered when distributing residents' clean clothes. On May 3, 2013 LPN#2 was counseled by the Director of Nursing on the infection control	6/15/2013



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F 441	<p>Continued From page 12</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies, it was determined the facility failed to cover resident clothing on the one (1) of one (1) delivery cart during the distribution of clean clothes to the residents. In addition, the facility failed to follow infection control procedures</p>	F 441	<p>procedures related to the importance of hand washing after performing any wound care.</p> <p>On May 6, 2013 the Wound Care Nurse was observed and monitored by the Director of Nursing during all her wound care procedures to assure proper hand washing was performed. On May 17, 2013 the Infection Control Nurse observed the Laundry Department with the delivery of the resident's clean clothing to assure all residents clothing was covered when going from one residents' room to another.</p> <p>All staff was in-serviced on May 15, 2013 by the Staff Development Coordinator on keeping residents clothing covered when going from one residents' room to another. All staff was in-serviced by the Staff Development Coordinator on May 15, 2013 on infection control procedures related to hand washing.</p> <p>An audit conducted by the Staff Development Coordinator on the proper delivery of residents' clean clothing has been completed. The audit will be completed weekly for 4 weeks, then monthly until 100% compliance is achieved and then quarterly. This audit will be conducted as part of the facilities Quality Assurance program. An audit conducted by the Staff Development Coordinator on hand washing has been completed. The audit will be completed</p>		



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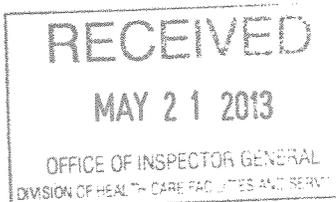
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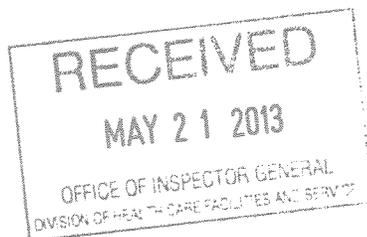
F 441	<p>Continued From page 13 related to handwashing during two (2) of two (2) sampled residents during dressing change procedures. (Residents #4 and #5)</p> <p>The findings include:</p> <p>1. Review of the facility's policy regarding Laundry-Handling of Linens and Personal Laundry, undated, revealed clean personal laundry was to be delivered in a covered cart.</p> <p>Observation, on 04/30/13 at 9:47 AM, revealed personal laundry delivered to residents in an uncovered laundry cart. The flap to cover the clothing was fully opened, exposing the resident's clothing. The cover was observed, as the cart went room to room, in a position that did not cover the clothing.</p> <p>Observation, on 05/01/13 at 1:30 PM, on the far end of the hall near the Belmont Dining Room, revealed the resident's clean clothing delivery cart, uncovered. Resident clothing was observed on the hanging rack and in the basket uncovered. A laundry person was in attendance.</p> <p>Interview, on 05/02/13 at 11:00 AM, with the Laundry Manager revealed the practice of the facility had been to deliver the laundry uncovered. She stated she knew the policy was to deliver the personal laundry to the residents covered; however, she and her staff had not been following the policy. She stated to deliver the clothing uncovered was how "we have always done it" and it had not been the expectation for the staff to deliver the resident's laundry covered. The Laundry Manager revealed the purpose to cover the resident's laundry during delivery was to</p>	F 441	weekly for 4 weeks then monthly until 100% compliance is achieved and then quarterly. This audit will be conducted as part of the facilities Quality Assurance program.	
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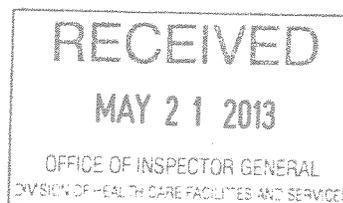
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F 441	Continued From page 14 protect the laundry from germs and for infection control reasons. She stated you would not want to expose the residents or the staff to germs.  2. Review of the facility's policy regarding Standard Precautions, undated, revealed hands were to be washed immediately after the removal of gloves to avoid transfer of microorganisms to other residents or environments.  Review of the facility's policy regarding Handwashing, undated, revealed hands were to be washed after the removal of gloves. The policy stated in areas/rooms where sinks were not readily available, a waterless antiseptic hand preparation may be used between tasks that would normally require handwashing unless the hands were visibly soiled.  Observation of a dressing change for Resident #4, on 05/01/13 at 11:00 AM, revealed Licensed Practical Nurse (LPN) #2, who was also the Infection Control Nurse and Wound Care Nurse, removed her gloves after cleansing a decubiti and put on another pair of gloves before placing a clean dressing on the wound and without washing her hands.  Observation, on 05/01/13 at 11:20 AM, revealed LPN #2 removed her gloves after a dressing change for Resident #5. LPN #2 then used a hand gel to cleanse her hands and left the room. There was a sink with water present in the room; however, LPN #2 proceeded directly to the nursing station where she was observed charting. Her hands were not washed with soap and water.	F 441			



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F 441	<p>Continued From page 15</p> <p>Interview, on 05/02/13 at 7:45 AM, with LPN #1 revealed when doing a dressing change, hands were to be washed when gloves were changed and at the completion of the dressing change. Her stated reason to do this was you may have bacteria on your hands. She stated handwashing was one of the most important things in healthcare. She revealed she had been in-serviced on handwashing. She revealed if hands were not washed when indicated, staff could pass bacteria from one resident to another or staff could pass the germs to each other. She revealed the nurses on the floor monitored the handwashing of staff in their area.</p> <p>Interview, on 05/02/13 at 8:10 AM, with LPN #2 revealed she knew the policy on handwashing was to wash hands before and after a procedure, and when gloves were changed. She revealed hands were to be washed with soap and water when a dressing change was completed. LPN #2 revealed hands were washed for the prevention of infection and to "not spread anything". She stated she had been in-serviced on handwashing, and handwashing was monitored by the In-Service Coordinator. LPN #2 revealed, as the Infection Control Nurse, she was responsible for the facility infection control program, and that the program was being followed.</p> <p>Interview, on 05/02/13 at 10:15 AM, with the Director of Nursing (DON) revealed she had been in-serviced on the handwashing policy and knew hands were to be washed before and after a procedure and when gloves were removed, if during a procedure. She stated she monitored handwashing by random checks. The DON revealed the purposed for handwashing was for</p>	F 441			



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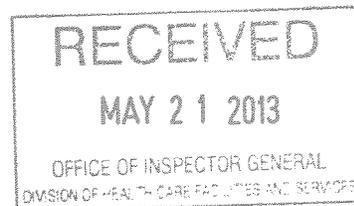
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F 441	Continued From page 16 infection control, that you would want to protect your residents and staff.	F 441		
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964, 1976 and 2010</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story with a partial Basement, Type V Protected Construction.</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system, pipe schedule design.</p> <p>GENERATOR: Two (2) Type II generators, 450 KW and 150KW, fuel source is diesel.</p> <p>A standard Life Safety Code survey was initiated on 04/30/13 and concluded on 05/01/13. Grayson Manor Nursing Home was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has seventy-two (72) certified beds with a census of sixty-nine (69) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>PLAN OF CORRECTION GRAYSON MANOR NURSING HOME SURVEY COMPLETION DATE OF May 01, 2013</p> <p>K018</p> <p>Door in resident's Room #32 was repaired by Maintenance Employee on May 3, 2013. Maintenance Director on May 3, 2013 inspected Room #32 door for proper functioning after repairs were complete.</p> <p>The Maintenance Director and a maintenance employee on May 3, 2013 audited all facility doors including resident's doors for proper functioning.</p> <p>In-Service Coordinator on May 15, 2013 educated all staff in proper door functions and proper reporting of malfunctions. The Maintenance Department Director with the help of the Quality Assurance Coordinator developed a weekly check off list for all facility door including resident's doors.</p>	6/15/2013

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

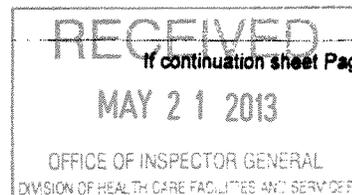
TITLE

(X6) DATE

*Joseph B. Vance*

*Administrator* 5/17/2013

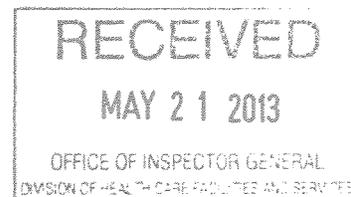
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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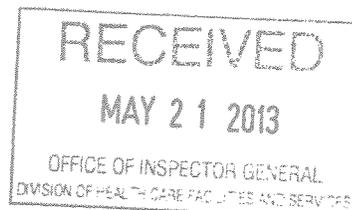
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K 000	Continued From page 1 Fire)	K 000	The Maintenance Director and Quality Assurance Coordinator will be responsible for implementing the weekly check off list for proper functioning of all facility doors including resident's doors into the Quality Assurance quarterly reporting.	
K 018 SS=D	Deficiencies were cited with the highest deficiency identified at "D" level. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors, to prevent the passage of smoke in the event of an emergency, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments	K 018		



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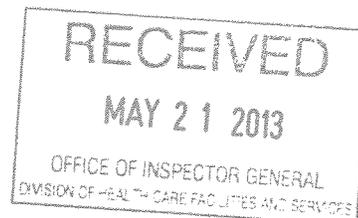
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185177	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  05/01/2013
NAME OF PROVIDER OR SUPPLIER  GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 505 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754	
(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
K 018	Continued From page 2 on the Ground Floor, approximately twenty (20) residents, staff, and visitors. The facility has seventy-two (72) certified beds and the census was sixty-nine (69) on the day of the survey.  The findings include:  Observation, on 04/30/13 at 10:30 AM, with the Maintenance Director revealed the door to resident room 32 was being propped open with a trash can. When the trash can was removed, the door proceeded to close without assistance.  Interview, on 04/30/13 at 10:30 AM, with the Maintenance Director revealed he was unaware of the door's malfunctioning and acknowledged the positioning of the trash can would be an impediment to the closing of the door, to resist the passage of smoke in the event of an emergency.  Reference: NFPA 101 (2000 edition)  19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms,	K 018		



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NAME OF PROVIDER OR SUPPLIER  <b>GRAYSON MANOR NURSING HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>505 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754</b>		
(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
K 018	<p>Continued From page 3</p> <p>bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.</p> <p>19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p>	K 018		
K 046 SS=D		K 046		



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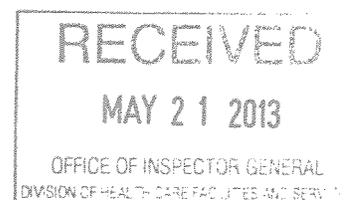
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185177	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  05/01/2013
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K 046	Continued From page 4 Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments on the Ground Floor, residents, staff and visitors. The facility has seventy-two (72) certified beds and the census was sixty-nine (69) on the days of the survey.  The findings include:  Observation, on 05/01/13 at 8:20 AM, with the Maintenance Director revealed the emergency light and exit sign located at the exit from the Staff Dining area, was not illuminated and did not function when tested.  Interview, on 05/01/13 at 8:20 AM, with the Maintenance Director revealed he was not aware the emergency light and exit sign had stopped functioning.  Record review, on 05/01/13 at 8:30 AM, with the Maintenance Director revealed the facility had been conducting the required thirty (30) second monthly test for emergency lighting and provided proper documentation. However, the required annual test for one and one-half (1.50) continuous illumination had not been conducted.	K 046	K046  Electrician John Tomes and the Maintenance Director on May 3 2013 repaired emergency light and exit sign located at the exit in the staffing dining area and performed 1 ½ hour test on the emergency light and exit sign.  Maintenance Director and Electrician John Tomes examined and tested 1 ½ hours all emergency lights and exit signs thru out the entire facility.  The In-Service Coordinator on May 15, 2013 educated all staff in proper emergency lights and exit signs illumination and the proper reporting of malfunctions. The Maintenance Director with the help of the Quality Assurance Coordinator put the 1 ½ hour testing of emergency lights and exit signs on the existing preventive "Maintenance Yearly Check-Off List".  The Maintenance Director and Quality Assurance Coordinator will be responsible for implementing the annual check off list of 1 ½ hour testing of emergency lighting and exit	6/15/2013



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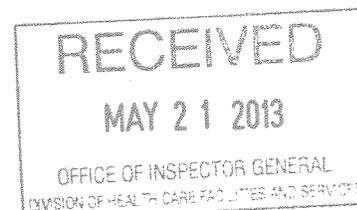
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185177	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  05/01/2013
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K 046	<p>Continued From page 5</p> <p>Interview, on 05/01/13 at 8:30 AM, with the Maintenance Director revealed he was unaware of the requirement for an annual emergency lighting test.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less</p>	K 046	signs into the Quality Assurance quarterly reporting.	



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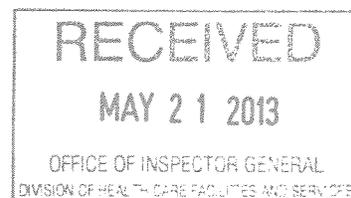
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K 046	Continued From page 6 than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards and failed to ensure the staff was knowledgeable of the requirements. The deficiency had the potential to affect two (2) of eight (8) smoke compartments on the Ground Floor, residents, staff, and visitors. The facility has seventy-two (72) certified beds and the census was sixty-nine (69) on the days of the survey.  The findings include:  1. Observation, on 04/30/13 at 9:40 AM, with the Maintenance Director revealed the resident's personal reclining chair, located in adjoining non-certified Room 2, was plugged into a power strip.  Interview, on 04/30/13 at 9:40 AM, with the Maintenance Director revealed he was unaware	K 147	K147  The Maintenance Director on April 30, 2013 removed power strips from Room #2 and Room #3. The Maintenance Director on May 1, 2013 removed the power strip from the Therapy Department.  Maintenance Director on May 6, 2013 audited entire facility for power strip usage.  The In-Service Coordinator on May 15, 2013 educated all staff on proper power strip usage and proper reporting procedures of the deficient practice. The Maintenance Director with the help of the Quality Assurance Coordinator has developed a weekly check off list that audits the entire facility for proper power strip uses.  The Maintenance Director and Quality Assurance Coordinator will be	6/15/2013



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K 147	<p>Continued From page 7 of the reclining chair being plugged into a power strip.</p> <p>2. Observation, on 04/30/13 at 9:45 AM, with the Maintenance Director revealed a refrigerator and a microwave oven, located in adjoining non-certified Room 3, were plugged into a power strip.</p> <p>Interview, on 04/30/13 at 9:45 AM, with the Maintenance Director revealed he was aware of the requirement for the usage of power strips; however, he was not aware of a refrigerator and a microwave oven being plugged into a power strip in the resident's room.</p> <p>3. Observation, on 05/01/13 at 9:05 AM, with the Maintenance Director revealed medical equipment (a standing frame) was being powered by a power strip.</p> <p>Interview, on 05/01/13 at 9:05 AM, with the Maintenance Director revealed he was not aware of the Therapy Staff using a power strip to power medical equipment and informed the Staff of the requirement for medical equipment to be plugged directly into a wall outlet.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	responsible for implementing the weekly check off list for proper power strip usage into the Quality Assurance quarterly reporting.	



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