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

PRINTED: 06/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185177	A. BUILDING ____ B. WING ____	C 05/31/2012
NAME OF PROVIDER OR SUPPLIER: GRAYSON MANOR NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE: 505 WILLIAM THOMASON BYWAY, LEITCHFIELD, KY 42754	

RECEIVED JUN 2012 OFFICE OF INSPECTOR GENERAL

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated survey (KY #18415) was conducted on 05/30/12 through 05/31/12 to determine the facility's compliance with Federal requirements. KY #18415 was substantiated with deficiencies cited.	F 000	**PLAN OF CORRECTION GRAYSON MANOR NURSING HOME SURVEY COMPLETION DATE OF May 31, 2012**	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to promote care for residents in a manner that enhanced each resident's dignity and respect for one resident (#3), in the selected sample of four residents, as evidenced by the failure to follow their Dignity/Respect policy/procedure. An observation during the abbreviated survey revealed Resident #3 was wearing two incontinent briefs. On 05/31/12 at 4:00 PM, the resident revealed he/she overheard an employee (aide) comment about changing his/her brief, and having to change the entire bed. The resident revealed the comment was degrading and made him/her "feel like less than people." Resident #3 was visibly upset and crying during the interview with the surveyor, which was 121 days after the incident. Findings include:	F 241	F 241 The nurse aides in resident #3's section were counseled regarding the dignity issue of using 2 briefs on one resident and a voice message was sent to all Charge Nurses regarding this deficient practice on June 1, 2012. After the Director of Nursing assessed the resident #3, bariatric briefs were obtained for resident #3 to provide increased security. On 01/24/2012, a grievance was filed by resident #3 and the nurse aide in question was immediately removed as a caregiver for resident #3. The nurse aide in question was verbally counseled regarding dignity and respect of resident #3. The nurse aide in question was never scheduled in resident #3's section again. The nurse aide in question is no longer employed at Grayson Manor. All residents' who wear briefs/pull-up's have been assessed by an Administrative Nurse to ascertain that no other incident's of resident's wearing two briefs were found. Bariatric briefs were ordered and will be kept in stock for any resident requiring additional security. An all page voicemail to all charge nurses was left to ensure future use of two briefs per resident did not occur.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joyce B Vance — TITLE: Administrator — (X6) DATE: June 22, 2012

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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NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 605 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754	

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F 241	Continued From page 1 A review of the facility's "Dignity/Respect" guidance from the 6th addition of Mosby's Textbook for LTC Assistants, as of 07/01/97, revealed appropriate measures to promote dignity and privacy were to use the right tone of voice. Do not yell, scold, or embarrass the person. Measures would be taken to assure the residents were treated in a courteous and dignified manner. The staff would promote independence and dignity in dining. Additionally, the measure for "Persons With Urinary Incontinence" revealed staff should answer signal lights promptly. The need to void may be urgent. A record review revealed the facility admitted Resident #3 on 05/08/09, and re-admitted on 01/24/12, with diagnoses to include Parkinson's Disease, Congestive Heart Failure (CHF), Narcolepsy, Morbid Obesity, and Neurogenic Bladder. A review of the quarterly Minimum Data Set (MDS), dated 04/23/12, revealed the facility identified the resident as cognitively intact and required extensive assistance of two staff for toilet use. An observation, on 05/31/12 at 8:11 AM, revealed Resident #3 was wearing two incontinent briefs, and there were two disposable incontinent briefs underneath the resident. An interview with Licensed Practical Nurse (LPN) #1, on 05/31/12 at 8:11 AM, revealed it was not facility practice to put two incontinent briefs on a resident. The resident was a heavy wetter and the resident requested two briefs be placed on him/her at times.	F 241	Resident Representative interviewed ALL residents for any dignity issues or concerns that any resident might have. The Staff Development Coordinator on June 20th, 2012 in-serviced all staff regarding Dignity and Respect and specifically that it is not standard procedure to apply two briefs on a resident. An audit conducted by the Social Services Director related to dignity and respect has been completed. The audits will be completed weekly for four weeks, then monthly until 100% compliance is achieved and then quarterly. This audit will be conducted as part of the facility's Quality Assurance Program.	7/15/2012

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F 241	Continued From page 2 An interview with Resident #3, on 05/31/12 at 7:05 AM, and at 4:00 PM, revealed he/she waited "quite awhile" before someone came to assist him/her, and stated he/she waited as much as two hours in a wet bed for someone because they did not have enough help. On 05/30/12, the staff started putting two briefs on him/her. Prior to 05/30/12, he/she used pads. The put two or three pads underneath him/her to keep from having to change the whole bed. Resident #3 revealed he/she did not like wearing the multiple briefs because it rubbed his/her legs, but had not told anybody but "the girls." Additionally, Resident #3 voiced the aides did not like to change him/her. The resident revealed, on 01/24/12, he/she overheard an aide out in the hall make a comment that "[he/she] peed again, we'll have to change the bed. I just changed [him/her]." The resident revealed the comment was degrading and made him/her feel like he/she "was less than people." He/she revealed the comment was reported to someone that day and they provided him/her with another aide that day. On 05/31/12 at 4:00 PM, an observation during a resident interview, 121 days after the incident, revealed Resident #3 was visibly upset and crying while discussing the comment made by the aide in the hall. Further interview with LPN #1, on 05/31/12 at 3:36 PM, revealed she did recall the incident. The resident was "hollering" for her to come to the room. The resident told me about the incident and he/she was concerned but never teared up or cried. Resident #3 never alleged abuse but he/she did appear upset about the situation. She revealed she completed an official grievance on behalf of the resident related to what Resident #3	F 241		

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F 241	Continued From page 3 reported to her. After reporting the incident, she was not involved in the investigation. She revealed she did not know if the aide provided any further care to the resident. Additionally, she revealed the resident had not complained to her about the use of two incontinent briefs. An interview with the Social Service Director (SSD), on 05/31/12 at 12:35 PM, revealed she spoke with Resident #3 related to the grievance she received. The resident overheard the staff in the hall commenting about having to change the resident again. The SSD revealed the resident did not comment on how the situation made him/her feel. The complaint was not an allegation of abuse and the staff was not talking to Resident #3. The aide was out in the hall and the incident was addressed as inappropriate action by the aide. An interview with the Director of Nursing (DON), on 05/31/12 at 8:34 AM, revealed the aides go by the text books they were trained with in their classes. A text book is located at each nursing station for the staff to reference. She was made aware of the resident's compleints. The resident was large in size and he/she was afraid urine would come out of the brief. At the resident's request, two briefs are placed on him/her, but it is not the normal practice. He/she would ask for the two briefs when he/she was going out to a physician's visit so he/she would feel comfortable. Resident #3 had not compleined to her about wearing two briefs.	F 241		