

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

PRINTED: 12/21/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185177	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 806 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
F 000	INITIAL COMMENTS	F 000	PLAN OF CORRECTION GRAYSON MANOR NURSING HOME SURVEY COMPLETION DATE OF December 8, 2010	
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide care for five (5) of twenty (20) sampled residents in a dignified manner. Residents' #3, 8, 17, 18, and 19 were observed being fed by staff who were standing either beside or in front of the residents in the Churchill Dining and resident hallway, as well as resident rooms.</p> <p>The findings include:</p> <p>Review of the facility policy provided by the facility regarding Dignity states: The intent of this policy is to establish that each resident have dignity while living at Grayson Manor.....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/her individuality.</p> <p>1. Resident #8 was observed during the noon</p>	F 241	<p>F241</p> <p>On December 9, 2010, Certified Nurse Aides feeding residents 3, 8, 17, 18, &amp; 19 have been instructed, by the Director of Nursing not to stand when feeding. The staff feeding the residents listed above, have been instructed by the Director of Nursing too sit with the residents in order to make eye contact and provide socialization while the resident is eating. The chairs in Church-hill dining room, that the certified nurse aides sit in order to feed the residents, have been replaced with stools on December 17, 2010. The stools adjust for height and have rollers to help assure residents, listed above, can be fed with the staff member sitting down.</p> <p>On December 13, 2010, ALL residents in both dining rooms as well as ALL residents receiving</p>	1/21/2011

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

TITLE

(X6) DATE

*[Signature]*

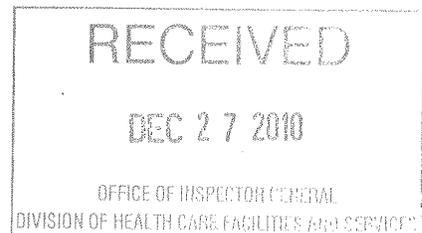
*Administrative Director 12/27/2010*

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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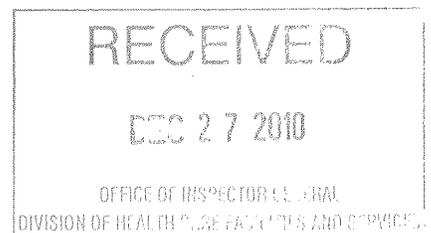
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NAME OF PROVIDER OR SUPPLIER  GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 805 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754	
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F 241	<p>Continued From page 1</p> <p>meal on 12/06/10 at 12:20pm being fed by a nursing assistant. During this time, the nursing assistant was observed to be standing during the entire time the resident was being fed and the resident was noted to be sitting very low or chin length to the edge of the table. Resident #8 was again observed to be fed by the nurse aide standing during the breakfast meal on 12/07/10 at 8:05am.</p> <p>Resident #8 was assessed on the quarterly MDS (minimum data set assessment) as having difficulty with decision making and minimal cognitive deficit, however interview with the resident on 12/06/10 at 3:30pm revealed the resident did not like the food.</p> <p>2. Observation on 12/07/10 at 12:20pm in the Churchill dining room revealed five nursing assistants and one charge nurse standing in front of residents while feeding them.</p> <p>Observation on 12/07/10 at 12:55pm revealed one CRNA observed feeding resident #19 while standing up and standing over the resident.</p> <p>Interview on 12/08/10 at 4:00pm with the Director of Nursing revealed restorative aides follow the CNA's to ensure they are following the correct procedures. Also, stated that the Director of Nursing is ultimately responsible for in services and nurses meetings once a month. She also added that staff had been in serviced to sit down and make eye contacting when feeding residents.</p> <p>3. Observation on 12/07/10 at 8:05am revealed Residents' #17 and #19 were being fed by the Certified Nurse Aide (CNA) standing during the</p>	F 241	<p>room service trays was observed by the Director of Nursing and Resident Assessment Instrument Coordinator. During observation no staff member was observed standing while feeding a resident.</p> <p>In-services were performed December 15, 2010 by Director of Nursing and Administrator that stated the deficient practice (standing while feeding residents). The standard of care was taught, at the in-service, to sit down when feeding a resident and making eye contact with them. The house supervisors/charge nurses have been instructed by voice mail and in-serviced on December 15, 2010 and in the monthly nurses meeting December 16, 2010 to monitor on a daily basis for proper feeding of residents.</p> <p>An audit concerning the dignity of residents has been conducted by Director of Nursing and House Supervisor to assure staff is sitting when feeding or assisting a resident to eat. This audit will be conducted daily for one week, then weekly for four weeks and then monthly until</p>	



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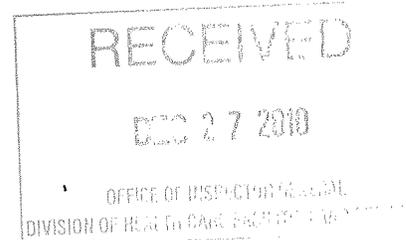
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NAME OF PROVIDER OR SUPPLIER  GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 505 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754	
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F 241	<p>Continued From page 2 entire breakfast meal on 12/07/10 at 8:05am. in the Churchill Dining Room.</p> <p>4. Observation on 12/08/10 at 7:36am during breakfast service revealed Resident #18 was sitting in the hallway outside of the resident's room being fed by Certified Medication Assistant/State Registered Nurses Aide (CMA/SRNA) #2.</p> <p>Interview on 12/08/10 at 3:15pm with CMA/SRNA #2 revealed Resident #18 was very disruptive and loud in the Dining Room. He/She reported this Resident was usually fed in the hallway and had been for the last few months. He/she reported Resident #18 did eat breakfast and lunch in the hall and was on a ground diet.</p> <p>5. Observation on 12/08/10 at 12:35pm during the lunch meal in the Churchill Dining Room revealed four (4) staff members stood up feeding residents.</p> <p>Observation on 12/07/10 at 12:25pm during the lunch meal in the Churchill Dining Room revealed six staff members stood up feeding residents. At 12:50pm on 12/07/10 during the lunch meal hall tray pass a CNA was observed standing up feeding Resident #3 in his room.</p> <p>Interview with Restorative Aide #1 revealed the staff were taught to sit down with the residents while feeding them. She stated staff were probably not seated because it was very difficult to do with the setup of how residents were seated at the half tables and the chairs that the staff use. When asked about standing and feeding residents she stated that standing while feeding residents may make the residents feel intimidated</p>	F 241	<p>100% compliance is achieved and then quarterly. This audit will be conducted as part of the facility Quality Assurance Program. Also the Certified Nurse Aides, Certified Medication Aides and all Charge Nurses will have an item added to their yearly evaluation that evaluates their participation with this standard of care that involves feeding the resident while sitting down and socializing with the resident.</p>	



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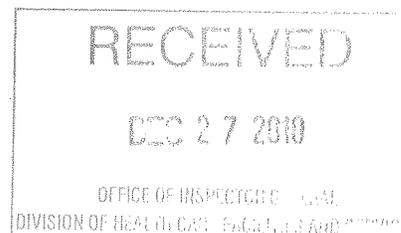
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F 241	Continued From page 3 or overwhelmed. She reiterated that she knew she was supposed to sit down with the residents while feeding them, and the rest of the staff know this because they are trained on this.	F 241		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide an environment free from accident hazards. Water temperatures were observed to be 160 degrees Fahrenheit (F) in rooms #62 and #64 on 12/07/10 at 5:05pm.  Findings include:  A facility policy regarding safe water temperatures was requested from the administrator on 12/08/10 at 10:15am. The administrator reported they did not have a policy available to provide at that time. The maintenance director provided a room safety checklist in which all resident rooms were checked for water temperatures in a safe range. The range they used was 104-110 degrees F. This was completed every six months; April and October. The maintenance director also provided a copy of the whirlpool weekly temperature	F 323	F323  On December 7, 2010 the Maintenance Supervisor and Administrator turned the power off to the water heater booster for rooms #62 & #64. The Maintenance Supervisor and Administrator did not allow any staff or residents into the bath rooms of #62 & #64 while they drained the hot water tank out until the temperature reached 98.3 and 98.0 degrees. The Maintenance supervisor put a pad lock on the disconnect along with a sign that stated do not take lock off without notifying him or the administrator. The next morning master plumber Paul Hughes installed a new hot water heater for rooms #62 & #64. On December 23, 2010 the booster hot water heater for rooms #62 & #64 were place on the weekly preventative maintenance check list.  On December 7, 2010 the Maintenance Supervisor and	1/21/2011



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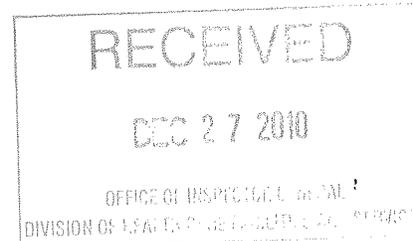
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F 323	<p>Continued From page 4</p> <p>checklist dated from 03/01/10 to 12/06/10 with all temperatures within a range of 103.0 degrees to 104.5 degrees F.</p> <p>On 12/07/10 at 5:06pm water temperatures were observed to be at 160 degrees Fahrenheit (F) in rooms 62 and 64. Room 62 was unoccupied and room 64 was occupied by Resident # 20, who was unable to access the water from the faucet independently. The wife of Resident #20 was in the resident's room and stated that the water temperature felt hotter than normal that afternoon. She stated she had been there about all day and that her husband was bed bound and did not use that bathroom. At 5:10pm the maintenance director checked the water temperature of room 62 and 64 with a digital thermometer and also got a temperature of 160 degrees F. The administrator and the maintenance director immediately began to run out all hot water from the hot water heater supplying those two resident rooms to get the temperature down. At 5:30pm the water temperature in room 62 was 119 degrees F. At 5:36pm the water temperature in room 62 was 98.3 degrees F and room 64 was 98.0 degrees F.</p> <p>Interview with the wife of resident #20 on 12/07/10 at 5:05pm revealed that she noticed the water temperature felt hotter that afternoon than normal. She stated that she did not burn herself and her husband was unable to get out of bed so he did not burn himself. She stated she had been in the resident's room visiting her husband just about the entire day.</p> <p>Interview with the Administrator on 12/07/10 at 5:30pm revealed that both rooms 62 and 64 are on a separate water heater than all other resident</p>	F 323	<p>Administrator reviewed ALL floor and plumbing plans for Hot Water Heater locations and checked water temps for ALL hot water heaters and made any necessary adjustments.</p> <p>On December 23, 2010 ALL hot water heaters were put on the weekly preventative maintenance check list. The facility policy was updated to include safe water temperatures.</p> <p>The Maintenance Supervisor and maintenance personnel will audit temps daily for one week until no deficient practice reoccurs then weekly. The results will be reported to the Quality Assurance Committee and Administrator. The Personnel Director will amend all Maintenance Department Staff annual evaluations to include the performance evaluation of water temps throughout the whole building.</p>	



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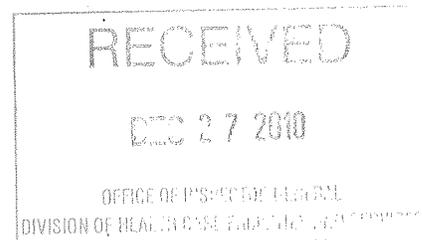
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F 323	Continued From page 5 rooms. He stated that they had never had a problem with water temperatures being elevated in those rooms before. He stated that he is running out all of the hot water from the hot water heater and that in the morning they would replace both elements in the hot water heater. At 6:15pm a facility policy on water temperatures was requested from the administrator.  Interview with the maintenance director on 12/07/10 at 5:35pm revealed he and another maintenance staff person checked the water temperatures for all rooms early that morning because of the inspection by the state as they wanted to catch any possible problems before they were found on inspection. The maintenance director stated the water temperature for rooms 62 and 64 were 102.2 degrees F. A statement was written and signed by the maintenance director and the maintenance staff person who was with him that morning stating the water temperature for room 64 was checked on 12/07/10 at 6:30am and was 102.2 degrees F. At 9:00am the water temperature for room 62 was checked and was 102.2 degrees F. The statement also noted that both rooms 62 and 64 run on the same water heater.  Interview with the administrator on 12/08/10 at 10:15am revealed he had not been down to the maintenance department to check if there was a policy on water temperatures in their department. He reported he did not have a policy available to provide.	F 323		
F 371 SS=D	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or	F 371	F371  On December 6, 2010 the Dietary Supervisor corrected the deficient practice by sealing and dating the containers within the refrigerators, freezers and dry storage areas that	1/21/2011



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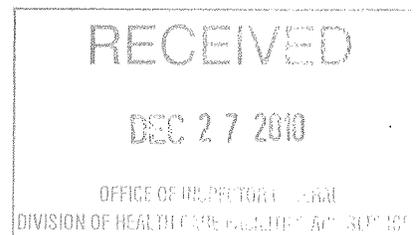
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F 371	Continued From page 6 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to store foods under sanitary conditions as evidenced by five (5) food items found open and unsealed in either dry storage or the freezer during the initial tour of the kitchen.  The findings include:  Review of the facility policy for freezer and refrigerator storage, which was undated, stated that leftovers should be refrigerated or frozen immediately. These foods should be stored airtight, dated, and identified by common name. The facility policy did not address food storage for food items that were opened, a partial amount used, and the remaining amount saved for future use.  During the initial tour of the kitchen on 12/08/10 at 8:10am one (1) box of pasta was found in the dry storage area open and unsealed. One (1) box of graham cracker crumbs was found in the dry storage area open and unsealed. One (1) box of boneless rib shape meat patties was found in the freezer open and unsealed. One (1) box of sausage patties was found in the freezer open and unsealed. And, one (1) box of frozen biscuits	F 371	were cited under the deficient practice.  On December 6, 2010 the Dietary Supervisor inspected ALL dietary food storage areas including freezers, refrigerators and dry storage areas for proper sealing and labeling. The Dietary Supervisor immediately corrected all deficient practices.  A Dietary Monthly meeting, on December 15, 2010, was conducted by the assistant dietary supervisor. The monthly meeting included in-servicing the dietary employees about the deficient practice of sealing and labeling food storage items and what is the correct practice of sealing and storage of food items. Also on December 15, 2010 the dietary department attended the facility wide in-service conducted by the Director of Nursing, Assistant Dietary Supervisor and Administrator that stated the deficient practice and the corrected actions and the proper procedures for storage and labeling of food items. On December 31, 2010 the Dietary Supervisor and Administrator	



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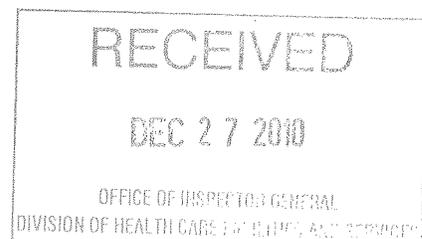
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F 371	Continued From page 7 was found in the freezer open and unsealed. The dietary director immediately sealed the items upon noticing they were unsealed.  Interview with the dietary director on 12/07/10 at 3:35pm revealed that the dietary staff had been trained to reseal food items when removing only a partial amount for use, as well as dating the items when opened. She stated she thought the staff may have been in a hurry and may be planned on going back and resealing the items, then got busy and just forgot. She acknowledged that by not resealing these food items the freshness and taste could be compromised, and there was a potential for contamination which could lead to illness. She stated that she would re-train staff on the importance of resealing food items after opening.	F 371	corrected the facility policy to address food storage for food items that are opened, a partial amount used and the remaining amount saved for future use.  After developing a check off list of all food storage areas the Dietary Supervisor and/or Dietary Cooks will audit daily for one week and once per week for four weeks then once per month for three months and then once a quarter for proper food storage. The Dietary Supervisor will report all results of audits to the Quality Assurance Committee. Also the Personnel Director will change the Dietary Supervisor's, Cook's, and Dietary Aids job description to include job performance specifically related to storage of food items.	
F 441 SS=D	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 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	F441  On December 9, 2010, Certified Nurse Aides feeding residents have been instructed by the Director of Nursing not to handle any resident food with bare hands. The staff	1/21/2011



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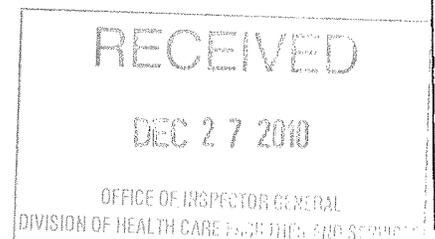
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F 441	<p>Continued From page 8</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin 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 record review, the facility failed to maintain proper infection control practices related to two staff members handling food served to two unsampled residents during two (2) meal observations.</p> <p>The findings include:</p> <p>The facility did not have a policy related to proper food handling procedures.</p> <p>Observation in the Churchill dining room on 12/06/10 at 12:20pm revealed a Restorative Aide #2 touched a resident's sandwich bread with bare hands and handed the sandwich to the resident.</p> <p>Interview on 12/06/10 with Restorative Aide #2</p>	F 441	<p>feeding the resident's, have been instructed by the Director of Nursing to always wear clean gloves when handling any resident's food.</p> <p>On December 13, 2010, Certified Nurse Aides were observed in both dining rooms as well as residents receiving room service trays for all three meals by the Director of Nursing and House Supervisor. During observation no staff member was observed handling food with their bare hands.</p> <p>In-services were performed on December 15, 2010 by the Director of Nursing and Administrator that stated the deficient practice of handling residents food with bare hands and what the standard of care should have been. The standard of care taught at the in-service was to always wear clean gloves when handling the resident's food. The house supervisor/charge nurses have been instructed by voice mail and in-service on December 15, 2010 and the monthly nurses meeting on December 16, 2010 to monitor on a</p>	



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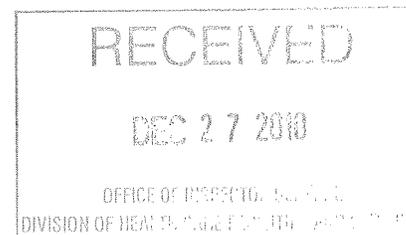
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186177	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/08/2010
NAME OF PROVIDER OR SUPPLIER  GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 605 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
F 441	Continued From page 9 revealed there was nothing wrong with touching the resident's food with bare hands. Also, the restorative aide stated the resident had to get the food, and the only way was to hand the food to the resident. She further added that it was "ok" to touch the resident's food with clean hands.  Observation in the Churchill dining room on 12/07/10 at 12:20pm revealed Restorative Aide #1 touched an unsampled resident's bread with bare hands.  Interview on 12/08/10 at 4:00pm with the Director of Nursing (DON) revealed restorative aides follow the CNA's to ensure they were following the correct procedures. Also, the DON stated that she was ultimately responsible for in-services and nurses meetings once a month. In addition, the DON stated that she monitored the dining room several times a week and staff should not be touching food with bare their hands. She also added that staff had been in-serviced to sit down and make eye contact when feeding residents.	F 441	daily basis for proper handling of residents food.  An audit concerning Infection Control (related to handling resident's food with bare hands) has been conducted by Director of Nursing and House Supervisor to assure staff is wearing gloves and not handling resident's food with bare hands. This audit will be conducted daily for one week, then weekly for four weeks and then monthly until 100% compliance is achieved and then quarterly. This audit will be conducted as part of the facility Quality Assurance Program. Also the Certified Nurse Aides, Certified Medication Aides and all Charge Nurses will have an item added to their yearly evaluation that evaluates their participation with this standard of care that involves wearing gloves when handling any resident food.	
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to ensure residents had access to the call light system when using a resident accesible bathroom beside the beauty/barber shop. Residents were observed during the	F 463	F463  Bathroom Door Lock  The Maintenance Supervisor on December 21, 2010 installed a coded	1/21/2011



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F 463	Continued From page 10 survey to enter the bathroom that did not have an emergency call light system in place.  The findings include:  An unsampled resident was observed entering the bathroom beside the beauty/barber shop on 12/06/10. Another unsampled resident was observed entering the same bathroom on 12/08/10. No emergency communication system was in place in this bathroom and it was accessible to staff, visitors, and residents throughout the survey.  Interview with the director of maintenance on 12/08/10 at 4:50pm confirmed this bathroom was used by residents as well as staff and visitors. He acknowledged there was no call light system in this bathroom and stated they had never had one in there. He also acknowledged this was a safety issue as residents could fall while in the bathroom and not have any way to alert staff. He stated he would put an emergency pull cord in the bathroom to correct the problem.  Interview with the administrator on 12/08/10 at 5:00pm confirmed this bathroom was used by residents as well as staff and visitors on a daily basis. He acknowledged that there was no call light system in this bathroom and stated they had never had one in there. He also acknowledged this was a safety concern because residents could fall while in the bathroom and not have any way to alert staff. He stated no one had fallen in there before, but knows there is a potential for that to occur. He stated the call system within the facility was too old to tap into again, so they would put a lock on that door with a keypad code. He also added that they were planning on getting a	F 463	key pad on the bathroom door – adjacent to the beauty shop.  On December 22, 2010 the Maintenance Supervisor and Administrator review ALL floor plans for call light system deficient's and noted none therefore no further additions or adjustments to the nurse call system was necessary.  The Housekeeping Supervisor on December 22, 2010 put the coded key pad for the bathroom door – adjacent to beauty shop on her "Nurse Call System Monthly Check List. All Staff within the nursing home was in-serviced December 15, 2010 regarding the deficient practice and what the standard of care should be in regards to nurse call system in bathrooms that are accessible to residents.  The Housekeeping Supervisor reports her finding (Nurse Call System Monthly Check List) to the Quality Assurance Committee, Maintenance Supervisor and Administrator. The Personnel Director will amend all Maintenance	



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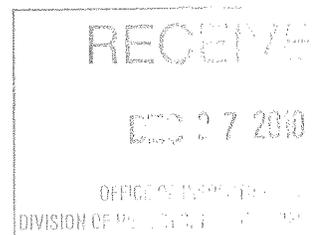
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NAME OF PROVIDER OR SUPPLIER  GRAYSON MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 805 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754
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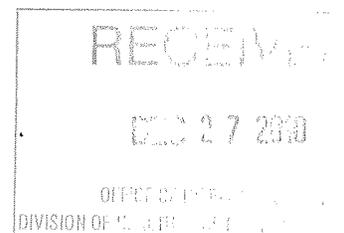
F 463	Continued From page 11	F 463	Department Staff annual evaluations to include the performance	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to maintain clinical records or yearly follow up on positive PPD results for one (1) of twenty (20) sampled residents (Resident #11).  The findings include:  Record review of the facility's Tuberculin Skin Testing policy, undated, revealed the facility is to assure that all residents who are positive reactors are reported and treated accordingly to the physician orders, regulatory requirements and to maintain up to date data on all residents, on admission and annually thereafter.  Record review of Resident #11 on 12/06/10	F 514	evaluation of nurse call system.  F514  On December 21, 2010 the Administrator, Director of Nursing and RAI Coordinator met with the TB Coordinator of the local health department, and Grayson Manor's Medical Director. Current CDC guidelines were discussed, and are being implemented in regards to resident #11. On December 23, 2010 Grayson Manor will initiate the following protocols for resident #11- obtaining three a.m. AFB sputum cultures, obtaining a chest x-ray, along with initiation of recommended drug regimen to include, INH 300 mg every day for a total of 9 months, Vitamin B6 100 mg every day for 9 months, along with Rifampin 300 mg every day for two months and following up with chest x-rays every six months for two years	1/21/2011



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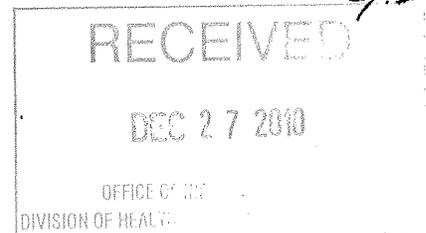
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NAME OF PROVIDER OR SUPPLIER  GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 805 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754	
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F 514	Continued From page 12 revealed the resident was admitted on 08/02/10 with the diagnosis of Essential Hypertension, Chronic Obstructive Pulmonary Disease, Depression, Acquired Hypothyroidism, Parkinson's Disease, Paralysis Agitans, Renal Failure and Hemodialysis. The resident was received from another facility with a known new positive PPD dated 06/26/10. The record revealed a Chest X-ray dated 06/26/10 indicating the radiologist reported right lower lobe infiltrates and to follow up to rule out active tuberculosis. The resident's physician ordered a seven (7) day course of Rifampin, the resident's TB medication.  Interview with the Director of Nurses (DON) on 12/08/10 at 03:55pm revealed she was unable to provide any additional documentation to determine when Rifampin treatment was initiated for TB or how long the resident was treated. She reported she did call the previous facility, and was unable to provide any details pertaining to the resident's course of treatment or the length of his medication regime for TB.	F 514	On December 18, 2010 all residents' medical charts were reviewed by House Supervisor and ALL past positive reactors were identified and all negative reactors were given a PPD test. Each resident with known positive PPD reaction, along with any new admissions who are positive reactors will be treated according to the CDC guidelines which are immediate chest x-ray (along with Medical Director required a.m. AFB sputum cultures for three days) and receive drug regimen therapy for a minimum of 9 months . All residents admitted to the facility will continue to receive two step PPD's along with yearly follow up as long as all results are negative.  Grayson Manor's Nursing Policy and Procedure manual, in regards to PPD's, has been changed on December 23, 2010 to reflect the CDC guidelines and the additional requirements of the Medical Director. All licensed staff has been given a copy of the updated Policy and Procedure manual by the Director of Nursing, each licensed <b>Continued On Page 14</b>	



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NAME OF PROVIDER OR SUPPLIER  GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 508 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754		
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F 514	Continued From page 42-13 <i>q.B.V.</i>	F 514	<p>staff has a copy of the Nursing Policy and Procedure Manuel. The Director of Nursing has a check off list that includes all licensed staff and when she in-service each individual to be completed by December 31, 2010.</p> <p>A separate audit by the Medical Records Director concerning monitoring and follow up on all positive PPD reactors will be conducted by December 31, 2010. The Medical Records Director will do a follow up audit once a quarter of all residents to check identification of any new positive PPD reactors in the facility and that the Updated PPD Policy was implemented and carried out and report to the Quality Assurance team quarterly with the results. The Personnel Director and Director of Nursing will review by December 31, 2010 the "Yearly Evaluation Forms" of ALL nursing staff to determine if additional performance evaluations for PPD policy and procedure compliance need to be added.</p>		



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NAME OF PROVIDER OR SUPPLIER  GRAYSON MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754
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K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and conducted on 12/06/2010 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*J. C. [Signature]* TITLE: *Administrator* (X6) DATE: *12/27/2010*

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.

