

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

PRINTED: 08/26/2015
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 _____	RECEIVED SEP 2015 INSPECTOR GENERAL	(X3) DATE SURVEY COMPLETED C 08/14/2015
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	
F 000	INITIAL COMMENTS An Abbreviated Survey investigating Complaint #KY23682 was conducted on 08/13/15 through 08/14/15. Complaint #KY23682 was substantiated with deficiencies cited at the highest Scope and Severity of a "D".	F 000	PLAN OF CORRECTION GRAYSON MANOR NURSING HOME SURVEY COMPLETION DATE OF August 14, 2015		
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 interview, record review, and facility policy review, it was determined the facility failed to promote care for residents in a manner and in an environment that maintains and enhances each resident's dignity and respect for one (1) of four (4) sampled residents (Resident #1). On 08/11/15, the Administrator placed his hands on Resident #1, pushed the resident against the wall twice and slapped his/her arm and hands after a verbal altercation in the hallway. Refer to F279. The findings include: Review of the facility Federal Residents Rights Form, not dated, revealed the facility shall protect and promote the rights of each resident to include the right to a dignified existence. Record review revealed the facility admitted Resident #1 on 08/31/13 with diagnoses which included Alzheimer's Disease, Psychosis,	F 241	F 241 On August 13, 2015, the Administrator immediately excused himself from the building pending Office of Inspector General Investigation. Resident #1 was assessed for injury by the Wound Care Nurse and Office of Inspector General Representative. All interviewable residents were interviewed by the Social Services Director and/or Social Services Assistant to ensure that they felt they have been treated with dignity and respect by all staff including the Administrator by August 18, 2015. There were no deficient		

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

TITLE

(X6) DATE

Joseph M. Vance Administrator *Sept 19, 2015*

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 505 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754	
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F 241	<p>Continued From page 1</p> <p>Parkinson's, Chronic Kidney Disease Stage II, Hypertension and Depression. Review of the a Significant Change Minimum Data Set (MDS) assessment, dated 07/11/15, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of a three (3) which indicated the resident was not interviewable.</p> <p>Observation of Resident #1, on 08/13/15 at 8:30 am, revealed him sitting in his room in a chair sleeping. He was well groomed and dressed with no concerns noted.</p> <p>Interview with Certified Nurse Aide (CNA) #2, on 08/13/15 at 12:37 PM, revealed on 08/11/15 she was walking down the hall and Licensed Practical Nurse (LPN) #1 was in the hallway standing with Resident #1. She stated the Administrator was in the hallway and the resident became agitated as he/she does not like males. She revealed prior to the Administrator coming down the hall, Resident #1 was calm, but after the Administrator got in the resident's face Resident #1 became verbally aggressive and that was when the Administrator put his hands on the resident.</p> <p>Interview with CNA #1, on 08/13/15 at 2:12 PM, revealed she was working the back hall and was stopped in the hallway talking with co-workers and she could see Resident #1 standing in the hallway by room #4 with the Charge Nurse, LPN #1. She stated she saw the Administrator come around the corner of the hallway and he appeared to be focused on something and was staring straight ahead. She revealed she was watching the Administrator as he walked up the hallway and he stopped in front of Resident #1 and got in the resident's face and the resident made a fist</p>	F 241	<p>practices identified. All non-interviewable residents will be observed by the Social Services Director and/or Social Services Assistant to ensure that they are treated with dignity and respect by all staff including the Administrator by August 18, 2015.</p> <p>Social Services Director presented an all staff in service (Including the Administrator) on August 13, 2015 on treating residents with dignity and respect. Staff was required to take a post test with a score of 100 %. This inservice was mandatory and staff that could not attend were required to complete the inservice and a post test with a score of 100 % before they were allowed to have contact with the residents. An all staff (Including the Administrator) mandatory inservice is scheduled for September, 17 2015 with Katrina</p>	

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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 2</p> <p>and put his/her hand up in the air but did not attempt to hit the Administrator. She stated the Administrator took the resident's arms and folded them across his/her chest and pushed the resident up against the wall, walked him/her past the door of room #64, pushed him/her up against the wall again, then pushed the resident into room #64 and had the Charge Nurse close the door. CNA #1 revealed she could hear a slapping sound but could not be sure if the resident was being slapped or if the resident was hitting his/her hand in his/her fist which he/she was known to do when he/she was upset. She stated she was at the kiosk charting in the hallway outside room #64 and LPN #1 came out of the room and asked her to go in the room with the resident and the Administrator. She stated she entered the room and Resident #1 was standing by the window with the Administrator on one side of him and she stood on the other side of the Administrator. She revealed the resident pointed out the window and when he/she did, the Administrator smacked his/her arm down and told the resident he/she was not going outside and the doctor was coming to get him. She stated after that occurred, she got in between the resident and the Administrator and attempted to calm the resident and the Administrator walked out of the room. She stated she got the resident to sit down.</p> <p>Interview with LPN #1, on 08/13/15 at 10:57 AM and on 08/14/15 at 7:38 PM, revealed on 08/11/15 at approximately 5:00 PM, the Administrator was walking down the hallway pushing his mother in law in a wheel chair to show her a new room and was accompanied by his wife. He stopped in front of Resident #1 who was standing in the hallway with LPN #1 and Resident #1 began to curse at the Administrator</p>	F 241	<p>Valliant, Ombudsman presenting an inservice on how to deal with combative residents while maintaining their dignity and respect.</p> <p>The Quality Assurance Coordinator implemented, on September 3, 2015, an audit on resident dignity that will be performed by Social Services to observe as well as interview residents to insure that they are treated with dignity and respect by all staff members to include administrative staff. This audit of twenty randomly selective residents will be conducted weekly times four weeks then monthly times three months then quarterly (every three months) maintaining 100 % compliance. This audit will be conducted as part of the facility's Quality Assurance program.</p>	9/18/2015

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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 3</p> <p>and was acting like he/she was going to hit the Administrator but did not. She revealed Resident #1 did not like males for some reason and became agitated when a male got too close to him/her. She stated the Administrator proceeded on down the hall and then came back up the hall and got in Resident #1's face and the resident got agitated again and the Administrator took the resident's arms and pushed the resident up against the wall and put the resident in room #64 and asked her to close the door. She stated she, the Administrator, and Resident #1 were in the room with the door closed and the Administrator and the resident were slapping at each other and the Administrator kept asking her what he should do. She revealed she told him the resident had just returned that day from a behavioral facility and all she could do would be to call the doctor to attempt to get him sent out again. She stated she asked CNA #1 to come in the room to try to keep the resident calm. She stated she called the Social Services Director, (SSD), then the Director of Nursing (DON). She stated the DON told her there was not much she could have done about the situation and for her to call the SSD to see if the resident could be sent out again.</p> <p>Interview with the Administrator, on 08/14/15 at 9:10 AM, revealed he was assisting a new resident to his/her room and when he turned the corner of the hallway, he noticed Resident #1 and LPN #1 standing in the hallway and the hallway was blocked causing him to have to stop in front of the resident. He stated the resident he was wheeling down the hallway family was behind him and Resident #1 went ballistic cursing at him and LPN #1 yelled "don't hit him" speaking to the resident. He stated he got the new resident to his/her room and came back up the hall where</p>	F 241			

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NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 608 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754		
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F 241	Continued From page 4 Resident #1 was as quick as he could because he was afraid Resident #1 was going to hit another resident. He stated Resident #1 began to come after him and he grabbed both of the resident's arms and room #84 was empty and he pushed the resident into the room. He stated he asked the resident to stay arms length away from him but the resident kept charging at him. He stated he asked LPN #1 to leave the room and call SSD #1 to see about having the resident sent out again and CNA #1 entered the room and approached the resident and asked him/her what was wrong and it was like a "light bulb" going on as Resident #1 calmed down and focused on her. He stated he asked SSD's to visit another behavioral hospital to inquire about placement of the resident elsewhere. He stated he came back down the hall because he was concerned for other resident's safety. He revealed if he witnessed a staff member do the same thing to a resident, he would relieve the staff member to keep them from being in that type of situation because everyone needed to protect themselves and he was there to protect all.	F 241			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	F 279 The Care Plan for Mood/Behavior for Resident # 1 was immediately revised to include the dislike of		

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F 279	<p>Continued From page 5</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the Resident Assessment Instrument (RAI) User Manual, Version 3.0, it was determined the facility failed to revise the care plan for one (1) of four (4) sampled residents (Resident #1). Staff interviews revealed Resident #1 would become very agitated and aggressive with male staff; however, the facility failed to revise the care plan to address Resident #1's dislike of male care givers.</p> <p>The findings include:</p> <p>Review of the RAI User Manual, Version 3.0, revealed the Comprehensive Care Plan should be reviewed and revised as needed.</p> <p>Record review revealed the facility admitted Resident #1 on 08/31/13 with diagnoses which included Alzheimer's Disease, Psychosis, Parkinson's, Chronic Kidney Disease St II, and Depression. Review of the Significant Change Minimum Data Set (MDS) assessment, dated 07/11/15, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of a three (3).</p>	F 279	<p>male caregivers on August 13, 2015.</p> <p>All residents Mood/Behavior Care Plans were reviewed by Social Services Director and/or Social Services Assistant to ensure that any issues related to care involving a specific gender was addressed by September 4, 2015.</p> <p>On August 13, 2015 the Director of Nursing educated the Social Services on guidelines for developing care plans to address specific behaviors to include but not limited to, dislike for specific gender of care givers. Social Services Director presented an all staff (Including the Administrator) inservice on August 14, 2015 on treating residents with dignity and respect as well as addressing specific behaviors to include but not limited to dislike for specific gender of care givers and the</p>		

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F 279	Continued From page 6 Interview with Licensed Practical Nurse (LPN) #1, on 08/13/15 at 10:57 AM, and Certified Nurse Aide (CNA) #1 on 08/13/15 at 2:12 PM, and CNA #2, on 08/13/15 at 12:37 PM, revealed Resident #1 did not like males for some reason and became agitated when a male got too close to him/her; however, review of the Comprehensive Care Plan, dated 07/29/15, revealed Resident #1 was care planned for wandering and exit seeking behaviors, however, there was no revision to the care plan to address Resident #1's dislike of males and agitation and aggression towards males. Further interviews with LPN #1, on 08/13/15 at 10:57 AM, and CNA #1 on 08/13/15 at 2:12 PM, revealed on 08/11/15 at 5:00 PM, the Administrator (male) was walking down the hallway pushing his mother in law in a wheel chair to show her a new room and was accompanied by his wife. They stated the Administrator stopped in front of Resident #1 who was standing in the hallway with LPN #1 and Resident #1 began to curse at the Administrator and was acting like he/she was going to hit the Administrator but did not. They stated the Administrator proceeded on down the hall and then came back up the hall and got in Resident #1's face and the resident got agitated again and the Administrator took the resident's arms and pushed the resident up against the wall and put the resident in room #64 and asked her to close the door. LPN #1 stated she, the Administrator, and Resident #1 were in the room with the door closed and the Administrator and the resident were slapping at each other and the Administrator kept asking her what he should do. She revealed she told him the resident had just returned that day from a	F 279	importance of all staff providing care being educated in this. Staff was required to take a post test with a score of 100 %. This inservice was mandatory and staff that could not attend were required to complete the inservice and a post test with a score of 100 % before they were allowed to have contact with the residents. The Quality Assurance Coordinator implemented, on August 18, 2015, an audit on monitoring care plans to make sure specific behaviors to include but not limited to dislike for specific gender of care givers is addressed. It will be conducted weekly times four weeks then monthly times 3 months then quarterly (every three months) maintaining 100 % compliance. This audit will be conducted as part of the facility's quality assurance program and will be done by the Quality Assurance Coordinator.	9/18/2015	

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F 279	<p>Continued From page 7</p> <p>behavioral facility and all she could do would be to call the doctor to attempt to get him sent out again. CNA #1 stated when she went into the room Resident #1 was standing by the window with the Administrator on one side of him and she stood on the other side of the Administrator. CNA #1 stated the resident pointed out the window and when he/she did, the Administrator smacked his/her arm down and told the resident he/she was not going outside and the doctor was coming to get him. CNA #1 stated after that occurred, she got in between the resident and the Administrator and attempted to calm the resident and the Administrator walked out of the room. She stated she got the resident to sit down.</p> <p>Interview with the Director of Nursing (DON), on 08/13/15 at 8:00 AM, revealed anytime Resident #1 came in contact with a male he/she became agitated. The DON stated Resident #1's Comprehensive Care Plan should have been revised to address Resident #1's dislike of males.</p>	F 279			