

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



PRINTED: 07/17/2015
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 _____		(X3) DATE SURVEY COMPLETED 07/02/2015
NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 608 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 A Recertification Survey was conducted on 06/03/15 through 07/02/15 to determine compliance with Federal requirements. The facility failed to meet minimum requirements for Recertification with the highest Scope and Severity cited at a "E".	F 000	PLAN OF CORRECTION GRAYSON MANOR NURSING HOME SURVEY COMPLETION DATE OF July 2, 2015		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	F 278 The Director of Nursing on 7/20/2015 documented incidents of inaccurate coding in the C-note in residents #1, #2 and #5. Resident #1 on assessment 5/21/2015 it was coded as two assist and in fact was set up only. Resident #2 on 4/23/2015 it was stated that resident required two staff members with eating in fact it was just one staff member. Resident #5 on assessment 5/21/2015 it was stated that resident required two staff members with eating in fact it was just one staff member. Maintenance on 7/2/2015 hung a		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joseph B. Vance TITLE: Administrator (X6) DATE: 7/21/2015

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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F 278	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to accurately code the Minimum Data Set (MDS) related to eating requirements for three (3) of fifteen sampled residents (Residents #1, Resident #2, and Resident #3).</p> <p>The findings include:</p> <p>Review of the Resident Assessment Instrument MDS Manual Version 3.0, dated 07/2013, revealed when conducting an MDS Assessment the MDS staff should review the documentation for the seven (7) day look back period, talk with direct care staff from each shift, and observe resident to determine his/her needs. When reviewing records, interviewing staff and observing the resident staff conducting the MDS Assessment must be specific when evaluating each component as listed in the Activities of Daily Living (ADL) activity definition. Further review of the manual for Section G, the Functional Status section under Section G0110E revealed eating is how resident eats and drinks, regardless of their skill. Review of instructions for rule of three (3), revealed when any activity occurs three (3) times at any one level, code that level.</p> <p>1. Record review revealed the facility admitted Resident #2 on 02/25/09 with diagnoses which included Alzheimer's Disease, Unspecified Psychosis, Congestive Heart Failure and Protein-Calorie Malnutrition.</p> <p>Review of the annual MDS assessment, dated 05/21/15, revealed the facility had assessed</p>	F 278	<p>cue card for accurately coding the late loss ADL's related to but not limited to eating by each of the kiosk in the entire Facility to include residents #1, #2 and #5.</p> <p>All MDS Assessments that were transmitted from July 3, 2015 thru July 17, 2015 have been reviewed for coding eating requirements by the MDS Coordinator on 7/17/2015 for all Skilled Nursing Facility residents. There were 2 other incidents of inaccurate coding of eating identified. The Nurse Aides involved received individual one on one counseling by the Nursing Personnel Director on 7/20/2015. The RAI Nurses documented incidents of inaccurate coding in the C-note in the residents permanent record 7/17/2015.</p>	

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NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 588 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754		
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F 278	<p>Continued From page 2</p> <p>Resident #2 as required two (2) staff to assist with eating.</p> <p>Observation, on 07/01/15 at 1:20 PM, revealed the resident was being fed by one (1) staff member.</p> <p>2. Record review revealed the facility admitted Resident #1 on 11/8/08 with diagnoses which included Weakness, Hypertension, Alzheimer's, Depression, Anxiety and Bipolar/Schizophrenia.</p> <p>Review of the annual Minimum Data Set (MDS), dated 05/21/15, revealed the facility assessed Resident #1 as requiring the assistance of two staff with eating.</p> <p>Observation, on 06/30/15 at 1:02 PM, revealed Resident #1 was eating independently.</p> <p>Interview with the CNA # 1 on 07/01/15 at 2:19 PM, revealed Resident #1 can feed him/herself without assistance.</p> <p>3. Record review revealed the facility admitted Resident #5 on 03/05/09 with diagnoses which included Unspecified Type Schizophrenia, Alzheimer's Disease, Hypertension, Osteoarthritis, Depressive Disorder, and Peripheral Disease.</p> <p>Review of Resident #5's annual MDS assessment, dated 04/23/15, revealed the facility assessed Resident #5's as requiring the assistance of two (2) staff.</p> <p>Observation, on 07/01/15 at 1:19 PM, revealed Resident #1 was being fed by one (1) staff member.</p>	F 278	<p>On 7/6/2015 all nurse aides were in-serviced by RAI Nurses on proper documentation of eating requirements in the kiosk. A yearly all staff in-service has and will be held by the RAI Nurses pertaining specifically to the coding requirements on late loss ADL's. Also per the Director of Nursing all future in-services regarding coding requirements will include a post-test related to ADL coding and all nursing staff must make a 100% to pass. The In-service Coordinator will train all newly hired Certified Nurse Aides on proper ADL coding as part of the orientation process. A post-test will be required with a 100% pass rate. All newly hired Certified Nurse Aides will be required to complete a minimum of one day on the floor training specifically pertaining to ADL coding with a Certified Nurse Aide Trainer.</p>		

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F 278	Continued From page 3 Interview with the MDS staff, on 01/01/15 at 3:25 PM, revealed the MDS for Residents #1, #2 and #5 were coded inaccurately in regards to the needs of the residents related to eating. She stated the inaccurate information came from the kiosk data entered by the CNAs. Interview with the Director of Nursing (DON), on 07/01/15 at 9:40 AM, revealed the coding was inaccurate. She stated she expected the coding to be accurate and will continue to educate and monitor staff performance.	F 278	The Quality Assurance Coordinator implemented a QA audit on proper documentation of ADL's to include but not limited to eating on the kiosk. This audit started the week of July 20, 2015 and will be done weekly for 4 weeks by the RAI nurses then monthly for 3 months then every three months (quarterly) maintaining 100 % compliance. This will be part of the facility's QA program. F 282 RN #1 immediately assessed Resident #1 and put care planed alarm(s) in place. Certified Nurse Aide #4 was given a verbal warning by RN #1 regarding resident #1's clip alarm not being in place on resident's wheelchair on 6/30/15 and was followed up	7/28/2015	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policy and procedure, it was determined the facility failed to provide services in accordance with each resident's written plan of care for one (1) of fifteen (1) sampled residents (Resident #1). Resident #1 was care planned to have a clip alarm; however, observation revealed Resident #1 was in his/her wheelchair with no clip alarm in place. The findings include: Interview, on 07/16/15 at 2:00 PM with the Director of Nursing (DON), revealed the facility	F 282			

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F 282	<p>Continued From page 4</p> <p>did not have a specific policy on following a care plan but followed the Center for Medicare and Medicaid Service's Resident Assessment Instrument Manual, Version 3.0 as there guide.</p> <p>Record review revealed the facility admitted Resident #1 on 11/8/08 with diagnoses which included Weakness, Hypertension, Alzheimer's, Depression, Anxiety and Bipolar/Schizophrenia.</p> <p>Review of the Annual Minimum Data Set (MDS), dated 05/21/15, revealed the facility assessed Resident #1's cognition as moderately impaired with a BIMS score of twelve (12) which indicated the resident was interviewable. Further review revealed the facility assessed the resident as requiring the total assistance of two (2) staff with transfers using a mechanical lift.</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 05/20/15, revealed to apply a clip alarm to bed and wheelchair due to resident being a high falls risk.</p> <p>Observation of the Resident #1 during tour, on 06/30/15 at 2:20 PM, revealed he/she did not have a clip alarm in place.</p> <p>Review of Event Report, dated 06/30/15, revealed on 06/30/15 at 6:30 PM, Resident #1 sustained a fall from the wheelchair and mechanical lift sling resulting in an abrasion to their back with reddened areas to both sides of the buttocks.</p> <p>Interview on 07/01/15 at 2:11 PM, with Certified Nurse Aide (CNA) #4 revealed the resident did not have a clip alarm on at the time of the fall. She stated this was her resident and the clip alarm should have be in place because it was on</p>	F 282	<p>with a written warning by Nursing Personnel Director.</p> <p>On July 17th 2015 all residents who have an order for a clip/pull alarm to their wheelchair were assessed by Nursing Administration while up in their wheelchair to ensure their alarm was secured to the resident. There were no residents found to not have an alarm attached to them.</p> <p>An All Staff In-service was held on July 15th 2015 by the In-service coordinator who specifically addressed Certified Nurse Aides following the Interdisciplinary care plan and Kiosk profile for securing clip/pull alarms to the residents who have an order for them after they are gotten up in the wheelchair.</p>		

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NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 503 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754	
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F 282	Continued From page 5 the resident's care plan. Interview on 07/02/15 at 9:14 AM with Registered Nurse (RN) #1 revealed she was called to Resident #1's room by the staff because the resident had fallen. She stated there was no clip alarm in place or sounding when she entered the room. Interview on 07/01/15 at 2:55 PM with Staff Development revealed staff should always follow the care plan and a clip alarm should have been in place at the time of the fall. She stated not following the care plan and not placing the clip alarm in place put the resident at risk of a fall due to staff not being made aware if the resident attempted to get up or was sliding down in wheelchair.	F 282	The Quality Assurance Coordinator implemented a QA audit on assistive devices to include but not limited to clip/pull alarms and sensor mats to insure proper placement. This audit will be done by the restorative nurse. It will be done weekly for 4 weeks then monthly for 3 months then every three months (quarterly) maintaining 100 % compliance. This will be part of the facility's QA program.	7/23/2015
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:	F 323	F 323 Resident #1 was assessed by RN #1 for injuries. Certified Nurse Aides #1, #2, #3 and #4 have been given a written warning by the Nursing Personnel Director	

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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 323	<p>Continued From page 6</p> <p>Based on observation, interview, record review and review of the facility policy and procedure, it was determined the facility failed to ensure that each resident receives adequate supervision and assistance devices to prevent accidents for one (1) of fifteen (15) sampled residents (Resident #1). Resident #1 was care planned for a clip alarm to wheelchair and bed and to use a mechanical lift for transfers. The facility failed ensure the clip alarm was in place when Resident #1 was in the wheelchair and failed to ensure the wheelchair was locked prior to transfer with a mechanical lift. In addition, the facility failed to ensure qualified staff participated in the transfer with the mechanical lift.</p> <p>The findings include:</p> <p>A review of the facility's policy titled, "Mechanical Lifts", dated 04/08/13, revealed a mechanical lift should be used to transfer residents to and from bed, wheelchair, shower chair, bedside commode and toilet. The appropriate type sling should be used depending on the type of transfer being performed. The policy indicated that no one under the age of 18 or any one that has not been properly trained should operate or assist with the use of a mechanical lift.</p> <p>Review of the Manufacturer's Operation and Maintenance Manual for the mechanical lift revealed a mechanical lift is approved with the proper use of their sling for the comfort and safety of the individual being lifted. All danger, warning and cautions must be followed for safe use of this type lift. When using a full body sling the resident must be positioned correctly in the sling before attempting to transfer resident and the wheelchair brakes should be engaged.</p>	F 323	<p>related to clip/pull alarm not being in place on resident #1's wheelchair and wheels not being locked on the wheel chair on 6/30/15.</p> <p>On July 17, 2015 all residents who have an order for a clip/pull alarm to their wheelchair were assessed by Nursing Administration while up in their wheelchair to ensure their alarm was secured to the resident. There were no residents care planed for an alarm that was found to not have an alarm attached to them. Certified Nurse Aides #1, #2, #3 and #4 have been evaluated by the DON and the Nursing Personnel Director for properly locking the wheels on the wheelchair prior to transferring a resident via Hoyer Lift. Any of the above staff that is on Family Medical Leave Act or Personal Leave of Absence will</p>		

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F 323	Continued From page 7 Review of the "United States Department of Labor, Wage and Hour Division", dated 02/2013, revealed the use of power-hoisting apparatus are particularly hazardous for minors between sixteen (16) and eighteen (18) which includes mechanical lift devices. Record review revealed the facility admitted Resident #1 on 11/8/08 with diagnoses which included Weakness, Hypertension, Alzheimer's, Depression, Anxiety and Bipolar/Schizophrenia. Review of the Annual Minimum Data Set (MDS), dated 05/21/15, revealed the facility assessed Resident #1's cognition as moderately impaired with a BIMS score of twelve (12) which indicated the resident was interviewable. Further review revealed the facility assessed the resident as requiring the total assistance of two (2) staff with transfers using a mechanical lift. Review of Resident #1's Comprehensive Care Plan, dated 05/20/15, revealed to apply a clip alarm to bed and wheelchair due to resident being a high falls risk. Additionally, a full body sling mechanical lift was to be used for transferring with two (2) person assist. Observation, on 06/30/15 at 1:02 PM, revealed Resident #1 was in the wheelchair with a lift sling under them and the clip alarm was not in place at that time. On 07/01/15 at 8:05 AM, during tour of the resident care area, the Minimal Data Set (MDS) Coordinator stated that Resident #1 had sustained a fall from the wheelchair on the night of 06/30/15.	F 323	not be allowed to work until this has been done. Certified Nurse Aide #5 per Facility Policy will not be allowed to use Hoyer Lift until he turns 18 years old and completes the training required and passes competency. On July 2, 2015 an In-service was held for All Nursing Staff by the In-service coordinator related to safety rules for mechanical lifts, locking the wheelchairs during transfers, alarms being attached when a resident is gotten up and appropriate age for use of mechanical lifts. Also part of the in-service included educating Certified Nurse Aides to always get the Nurse if unsure of the safety of any transfer. All Certified Nurse Aides were given a test involving the safety rules of using mechanical lifts and were required to make 100 %.	

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F 323	<p>Continued From page 8</p> <p>Review of the Event Report, dated 08/30/15, revealed the resident slid out of the chair while attempting to move with the mechanical lift. She was found on the floor by RN #1 complaining of back pain and was noted to have a small scratch to the right lower back and two (2) reddened areas to lower back.</p> <p>Interview, on 07/01/15 at 2:24 PM, with CNA #5, revealed he had walked by Resident #1's room on 6/30/15 and noted the resident was sliding out of the wheelchair. He stated he called for assistance because he was on "Fall's Risk" duty and when he reentered the room the resident was in the sling with staff attempting to transfer the resident back to bed. He said he lifted the resident's legs then the resident slid from the sling onto the wheelchair legs and onto the floor striking his/her back on the leg rest. He stated the nurse came in and the staff assisted the resident back into bed then she completed a head to toe assessment. He stated that he was under 18 and was not allowed to use a mechanical lift per facility policy.</p> <p>Interview on 07/01/15 at 2:11 PM with Certified Nurse Aide (CNA) #4 revealed on 08/30/15 she was assigned to Resident #1 who had been sitting in his/her wheelchair with a lift sling under him/her. She stated she was summoned because the resident had slid down in the sling and wheelchair. She confirmed that her and three (3) other staff attempted to lift the resident from the chair using the mechanical lift when the resident slid out of the sling onto the floor. She concluded that the brakes of the wheelchair were not locked and the wheelchair had also slid out from under the resident. She stated that no one under 18 years old were allowed to operate or</p>	F 323	<p>The Quality Assurance Coordinator implemented a QA audit on mechanical lifts and safe practices when using the lift to include but not limited to locking the chair. This audit will start for the week of July 20, 2015 and be completed by the Director of Nursing. This audit will be done weekly for 4 weeks, then monthly for 3 months, then once every three months (quarterly) maintaining 100 % compliance. This will be part of the facility's QA program. The Quality Assurance Coordinator implemented a QA audit on assistive devices to include but not limited to clip/pull alarms to insure proper placement. This audit will start for the week of July 20, 2015 and be completed by the restorative nurse. It will be done weekly for 4 weeks, then monthly for 3 months, then every three months (Quarterly)</p>		

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F 323	<p>Continued From page 9 assist with the sling.</p> <p>Interview on 07/01/15 at 1:42 PM, with Certified Nursing Assistant (CNA) #2, revealed on the evening of 06/30/15, she was called to Resident #1's room to assist with lifting the resident back into the wheelchair because the resident had slid down in the lift sling that was under him/her. She said three (3) other CNA's came in to assist with the repositioning. She revealed they were going to use the mechanical lift to transfer the resident but when they were attempting to start the lift process, one (1) CNA lifted the resident's legs and the resident slid out of the sling on to the floor and was partially on the wheelchair legs.</p> <p>Interview on 07/01/15 at 1:50 PM with CNA #3 revealed on 06/30/15 she was called to assist with a transfer of Resident #1 using a mechanical lift. She stated that the resident had partially slid out of the lift while sitting in the wheelchair. She stated that in the attempt to transfer him/her the resident slid from the mechanical lift sling onto the floor and wheelchair legs. She stated that it took five (5) staff to manually lift the resident back in to the bed.</p> <p>Interview on 07/01/15 at 2:19 PM, with Certified Nursing Assistant (CNA) #1, revealed she went into Resident #1's room and saw he/she had slid from the wheelchair on to the floor and other CNAs were in the room. She stated she went to get Registered Nurse (RN) #1 to come evaluate the resident. She stated the resident had a red spot on his/her back and later that night she noted a scratch to the resident's back and alerted the nurse on duty.</p> <p>Interview, on 07/02/15 at 8:14 AM, with RN #1,</p>	F 323	<p>maintaining 100 % compliance. This will be part of the facility's QA program.</p>	7/29/2015	

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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		
(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 323	<p>Continued From page 10</p> <p>revealed she was called to Resident #1's room by the staff on 06/30/15 and found that he/she had slid from the wheelchair onto the floor. She stated on arrival she found the resident sitting with half of their hips on the floor and half on the wheelchair legs; and, he/she was complaining of back pain. She stated the staff had changed their story several times but stated the resident slid out of the sling while attempting to transfer the resident. She stated the staff reported the resident was hooked to the lift when he/she slid out to the floor. RN#1 completed an assessment and noted Resident #1 to have a scratch to the lower back and two (2) red areas to both hips. She stated she verbally questioned the resident which only complained of pain to their back. She revealed when she arrived the sling was still hooked to the lift. She said she was never told the wheelchair had slid from under the resident because the breaks were not locked. She stated the staff had to manually lift the resident because the lift would not lower enough to hook the resident back to it. She claimed it took six (6) staff to pick the resident up from the floor and place him/her back in bed. She stated the husband was notified and the nurse faxed a note to the Physician of the incident. She confirmed that once the resident was placed in bed she completed a head to toe assessment and noted the same findings. She stated the staff told her they did not know how to move this resident because of the way he/she was originally positioned in the sling. She educated the CNAs that if ever in doubt to get the nurse before moving the resident.</p> <p>Interview, on 07/01/15 at 2:55 PM with Staff Development Nurse, revealed all new hire CNAs are trained during orientation on all mechanical</p>	F 323			

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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		
(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)	(X3) COMPLETION DATE	
F 323	<p>Continued From page 11</p> <p>lifts and annually which includes a competency lift check-off. She stated the staff are required to watch a video and then do a hands-on performance including being lifted themselves. She revealed there should always be two (2) CNAs or Nurses to use a Mechanical Lift and no one under the age of 18 are allowed to use or assist during the transfer of a resident using a mechanical lift per the United States Labor Law. She stated the wheelchair should always be locked during the use a mechanical lift transfer per the safety training which is covered in the new hire orientation and annual training. She confirmed Resident #1 required total care for transfers and depends on the staff to provide safe assistance. She stated that due to the labor law that CNA #5 should have not been in the area of the use of a mechanical lift. She confirmed that all the staff that were involved in this incident had received up-to-date training on the lifts which was verified by the Competency Assessment sheet of each employee. She stated the lack of the use of the wheelchair brakes placed the resident at risk. She confirmed that the facility policy reflects that anyone under 18 should not use mechanical lifts. Additionally, she confirmed that if a resident that is care planned for the use of a clip alarm, the staff should ensure the alarm is in place and functional for the safety of the resident.</p> <p>Interview, on 07/02/15 at 12:10 PM, with the Director of Nursing (DON) revealed she was not made aware of the incident until the next morning when she received the incident report. She confirmed there had been no form of education on mechanical lifts since the incident on 6/30/15 to date on 07/02/15. She stated she expected if the staff had any doubt of how to transfer the resident they should seek the advise of the nurse</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 808 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 323	Continued From page 12 on duty before moving the resident. She revealed it was policy that the wheelchair brakes must be locked when using a mechanical lift.	F 323	F 371		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or 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 review of the facility's policy/procedure, it was determined the facility failed to serve food under sanitary conditions as staff failed to use food tongs to retrieve food, and failed to prevent contamination of food on steam table. Review of the Census and Condition, dated 06/30/15, revealed there were sixty-four (64) residents in the building and three (3) residents received tube feedings. The findings include: Review of the "Sanitation and Infection Control" policy/procedure, dated 2003, revealed gloves should be worn while serving food from the steam table. If necessary to leave the steam table,	F 371	On 7/1/2015 the Dietary Supervisor immediately counseled Cook #1 to use appropriate utensils to include tongs to serve food. On 7/3/2015 the Dietary Supervisor counseled Cook #1 not to allow the pots to touch the food while filling the warmer and when gloves become soiled remove gloves, wash and dry hands and re-apply gloves. During lunch on 7/3/2015 the Dietary Supervisor monitored Cook #1 preparing meal trays for all residents with no incidents of cross contamination observed. Also no incidents of the food pots touching the food while filling the warmers. The dietary staff has been in-serviced by the dietary manager on 7/3/2015 on using proper utensils when serving meals and		

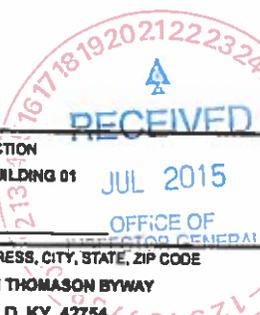
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NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 606 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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 371	<p>Continued From page 13</p> <p>wash hands and change gloves before returning. Change gloves if they become soiled or come into contact with any object other than food you are working with ex: cloths, pots/pans.</p> <p>Observation of the tray line, on 07/01/15 at 11:45 AM, revealed Cook #1 used her gloved hand to obtain a serving of shredded roast beef and placed it on a resident's plate, then the cook touched her clothing, then used the same gloved hand to obtain another serving of shredded roast beef without changing her gloves. In addition, Cook #1 placed a pot of stewed potatoes directly onto the shredded roast beef, while attempting to pour stewed potatoes into the warmer.</p> <p>Interview with Cook #1 on 07/02/15 at 10:15 AM, revealed she should have used tongs to obtain the shredded roast beef, and changed her gloves after touching her clothing. She stated the pot of stewed potatoes should not have been placed directly on the shredded roast beef, the container should have been placed in the serving line.</p> <p>Interview with the Dietary Manager, on 07/02/15 at 10:30 AM, revealed she would have expected Cook #1 to use tongs to serve the shredded roast beef instead of using gloves, but if she did use gloves she would have expected the gloves to be changed after touching her clothing. She stated the container of stewed potatoes should have been placed on the serving line and not directly on the shredded roast beef, this would be considered cross contamination.</p>	F 371	<p>properly filling pans on the steam table without cross-contamination. The in-service also included the risk of cross contamination during the serving process and how to avoid this.</p> <p>The Quality Assurance Coordinator implemented an audit on monitoring dietary staff as they served food to observe for incidence of cross contamination. The audit also included observation of the steam table pans being refilled without cross-contamination. The audit will begin for the week of July 20, 2015, and be completed by the Quality Assurance Coordinator and will be done weekly times 4, then monthly for 3 months, then every three months (quarterly) maintaining 100 % compliance. This audit will be conducted as part of the facility's Quality Assurance Program.</p>	7/28/2015	

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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	
(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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1964, 1976, & 2010.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1964 with twelve (12) smoke detectors and sixteen (16) heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1964 and upgraded in 2012.</p> <p>GENERATOR: Type II generator installed in 2010. Fuel source is Diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 07/01/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for seventy-two (72) beds with a census of sixty-four (64) 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 July 1, 2015</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Lytha B Vance* TITLE: *Administrator* DATE: *7/21/2015*

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 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
K 000	Continued From page 1 Fire).	K 000		
K 018 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ 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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms would latch properly in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, two (2) residents, staff and</p>	K 018	<p>K-018</p> <p>UL Tested and Classified for Fire and Smoke Doors Self Adhesive Silicone Seal manufactured by National Guard Products Inc was used to seal the gap in room 41 door on 7/14/15.</p> <p>Ed Cabbage Maintenance Supervisor and Allen Chambers Maintenance Assistant checked all doors in the facility on 7/3/15 to make sure there were no further deficient practices that lead to gaps in the doors and none was found.</p> <p>Joey Vance NHA in-serviced the Maintenance Department on 7/6/15 of the importance of</p>	

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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	
(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 2</p> <p>visitors. The facility has the capacity for seventy-two (72) beds and at the time of the survey, the census was sixty-four (64).</p> <p>The findings include:</p> <p>Observation, on 07/01/15 at 3:32 PM, with the Maintenance Supervisor revealed the corridor door to room #41 had a gap at the top of the door that was greater than one half (1/2) inch and would not resist the passage of smoke.</p> <p>Interview, on 07/01/15 at 3:33 PM, with the Maintenance Supervisor revealed he was unaware the door would not resist the passage of smoke.</p> <p>The census of sixty-four (64) was verified by the Administrator on 07/01/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 07/01/15.</p> <p>Actual NFPA Standard:</p> <p>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.</p>	K 018	<p>checking the doors routinely to insure there was no gaps in the closures.</p> <p>On 7/3/15 the Quality Assurance Coordinator implemented an audit that will check the doors to make sure that there are no gaps in the doors when closed. This audit will be done by the Maintenance Department and will be part of the facility's Quality Assurance program. This audit will be done weekly as part of the weekly door audit.</p>	7/28/2015

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NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 506 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 3 Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. 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. 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 NFPA standards.	K 018		
K 025 SS=E	Reference: CMS: S&C-07-18 NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025	K-025 Fire Stop Wolf Wool was ordered from Future Designs on 7/3/15 and will be used to fix the areas of penetration between the smoke walls and roof ridge cap. Ed Cabbage the Maintenance	

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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	
(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 025	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect five (5) of eight (8) smoke compartments, seventy-two (72) residents, staff and visitors. The facility has the capacity for seventy-two (72) beds and at the time of the survey, the census was sixty-four (64).</p> <p>The findings include:</p> <p>Observation, on 07/01/15 at 1:20 PM, with the Maintenance Supervisor revealed an unsealed penetration in each smoke barrier extending above the ceiling located in the attic. The penetration was due to a continuous ridge vent that was recently installed with the new roof.</p> <p>Interview, on 07/01/15 at 1:21 PM, with the Maintenance Supervisor revealed he was not aware the smoke barrier would not resist the passage of smoke due to the new ridge vent.</p> <p>The census of sixty-four (64) was verified by the Administrator on 07/01/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 07/01/15.</p> <p>Actual NFPA Standard:</p>	K 025	<p>Supervisor inspected all of the attic areas on 7/10/2015 for deficient practice of penetration and no further instances was found.</p> <p>The Maintenance Department was in-serviced on 7/2/15 by Joey Vance NHA regarding penetration in the attic area and the importance of checking periodically for areas of penetration.</p> <p>On 7/3/2015 the Quality Assurance Coordinator implemented an audit checking for penetration of the attic to be done every quarter by the maintenance supervisor and his assistant. This will be part of the facility Quality Assurance program.</p>	7/28/2015

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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
K 025	Continued From page 5 Reference: NFPA 101 (2000 Edition).19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. Reference: NFPA 101 (2000 Edition) 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose.	K 025		

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

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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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2016
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 025	Continued From page 6 (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility has the capacity for seventy-two (72) beds and at the time of the survey, the census was sixty-four (64). The findings include: Observation, on 07/01/15 at 3:50 PM, with the	K 029	K-029 Ed Cabbage and Allen Chambers of the Maintenance Department installed a door closure on the Director Of Nursing's office door on 7/6/15 due to computers be stored in there in boxes. Ed Cabbage checked all other areas within the facility on 7/3/15 to make sure there was no other area that stored combustible materials and was in need of a closure. No other areas were found. Joey Vance NHA in-serviced the Maintenance Department on the importance of door closures being on doors where	

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K 029	<p>Continued From page 7</p> <p>Maintenance Supervisor revealed hazardous amounts of combustible boxes with paper stored in the Director of Nursing Office. The door was not equipped with a self-closing device.</p> <p>Interview, on 07/01/15 at 3:51 PM, with the Maintenance Supervisor revealed he was not aware the boxes were being stored in the office.</p> <p>The census of sixty-four (64) was verified by the Administrator on 07/01/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 07/01/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.2 Protection from Hazards.</p> <p>Reference: NFPA 101 (2000 Edition) 9.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <p>(1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops</p>	K 029	<p>combustible materials were stored. The inservice was held on 7/6/15.</p> <p>On 7/3/15 the Quality Assurance Coordinator implemented an audit that will check the doors to make sure that closures were on all doors where combustible materials were stored. This audit will be done by the Maintenance Department and will be part of the facility's Quality Assurance program. This audit will be done weekly as part of the weekly door audit.</p>	7/29/2015	

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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 029	<p>Continued From page 8</p> <p>(5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 8.2.2.2 and 8.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon</p>	K 029		

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K 029	Continued From page 9 release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 029		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.8.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on sprinkler testing record review and interview, it was determined the facility failed to maintain the sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility has the capacity for seventy-two (72) beds and at the time of the survey, the census was sixty-four (64). The findings include: 1. Sprinkler testing record review, on 07/01/15 at	K 062	K-062 7/1/15 Ed Cabbage Maintenance Supervisor called Midwest to get a quote for an internal sprinkler pipe inspection and replacement of the gauges on the sprinkler riser. The bid was received on 7/01/15 and accepted 7/2/15. Ed Cabbage Maintenance Supervisor reviewed all other inspections mandated by Life Safety requirements on 7/6/15 to make sure all schedule requirements had been done. All	

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K 052	<p>Continued From page 10</p> <p>1:27 PM, with the Maintenance Supervisor revealed the facility failed to provide documentation that the internal pipe inspection for the sprinkler system had been performed within the last five (5) years. The last documented inspection was performed on 01/2010.</p> <p>Interview, on 07/01/15 at 1:28 PM, with the Maintenance Supervisor revealed the facility relied on the Sprinkler Testing Contractor to ensure the system was inspected properly as required.</p> <p>2. Sprinkler testing record review, on 07/01/15 at 2:16 PM, with the Maintenance Supervisor revealed the facility failed to provide documentation that the gauges on the sprinkler riser had been calibrated or replaced within the last five (5) years. The year on the gauges was 2008.</p> <p>Interview, on 07/01/15 at 2:17 PM, with the Maintenance Supervisor revealed the facility relied on the Sprinkler Testing Contractor to ensure the system was inspected properly as required.</p> <p>The census of sixty-four (64) was verified by the Administrator on 07/01/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 07/01/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and</p>	K 052	<p>others were up to date.</p> <p>Joey Vance the Administrator in-serviced all members of the Maintenance Department on guidelines for sprinkler inspections on 7/6/15. No others were found to be deficient.</p> <p>On 7/3/15 the Quality Assurance Coordinator implemented an audit on the sprinkler inspections to insure that they were done within a timely basis and that gauges on the sprinkler riser were recalibrated or replaced. This will be part of the facility Quality Assurance program. The audit will be done by the Maintenance Department.</p>	7/28/2015

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K 062	Continued From page 11 maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years	K 062			

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K 062	<p>Continued From page 12 thereafter</p> <p>2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter</p> <p>2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10</p> <p>Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Component Activity Frequency Reference Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 Alarm Valves Exterior Inspection Monthly 9-4.1.1 Interior Inspection 5 years 9-4.1.2 Strainers, filters, orifices Inspection 5 years 9-4.1.2 Check Valves Interior Inspection 5 years 9-4.2.1 Preaction/Deluge Valves Enclosure (during cold weather) Inspection Daily/weekly 9-4.3.1 Exterior Inspection Monthly 9-4.3.1.2 Interior Inspection Annually/5 years 9-4.3.1.3 Strainers, filters, orifices Inspection 5 years 9-4.3.1.4 Dry Pipe Valves/Quick-Opening Devices Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1 Exterior Inspection Monthly 9-4.4.1.3</p>	K 062		

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K 062	Continued From page 13 Interior Inspection Annually 9-4.4.1.4 Strainers, filters, orifices Inspection 5 years 9-4.4.1.5 Pressure Reducing and Relief Valves Sprinkler systems Inspection Quarterly 9-5.1.1 Hose connections Inspection Quarterly 9-5.2.1 Hose racks Inspection Quarterly 9-5.3.1 Fire pumps Casing relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1 Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1 Backflow Prevention Assemblies Reduced pressure Inspection Weekly/monthly 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1 Fire Department Connections Inspection Quarterly 9-7.1 Main Drains Test Annually 9-2.6, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7 Control Valves Position Test Annually 9-3.4.1 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Preaction/Deluge Valves Priming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2 Dry Pipe Valves/Quick-Opening Devices Priming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.6 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1 Pressure Reducing and Relief Valves Sprinkler systems Test 5 years 9-5.1.2 Circulation relief Test Annually 9-5.5.1.2	K 062		

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K 082	Continued From page 14 Pressure relief valves Test Annually 9-5.5.2.2 Hose connections Test 5 years 9-5.2.2 Hose racks Test 5 years 9-5.3.2 Backflow Prevention Assemblies Test Annually 9-6.2 Control Valves Maintenance Annually 9-3.5 Preaction/Deluge Valves Maintenance Annually 9-4.3.3.2 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2	K 082		
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on fire/smoke damper testing record review, and interview, it was determined the facility failed to ensure fire/smoke dampers were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility has the capacity for seventy-two (72) beds and at the time of the survey, the census was sixty-four (64). The findings include: Fire/smoke damper testing record review, on 07/01/15 at 1:42 PM, with the Maintenance Supervisor revealed the facility did not have documentation that fire/smoke dampers had	K 104	K-104 Ed Cabbage Maintenance Supervisor contacted Simons Heating and Air on 7/1/15 to inspect and replace dampers as needed. They are scheduled to complete this inspection on 7/27/2015. Simons Heating and Air have replaced and inspected according to appropriate guidelines facility wide all smoke and fire dampers. This will be completed on 7/27/2015. Joey Vance the Administrator in-serviced all members of the	

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K 104	Continued From page 15 been tested within the last four (4) years. Interview, on 07/01/15 at 1:43 PM, with the Maintenance Supervisor revealed he was not aware of the testing requirements for the fire/smoke dampers. Further interview confirmed the facility had fire/smoke dampers, however he was not aware of the number of fire/smoke dampers located throughout the facility. The census of sixty-four (64) was verified by the Administrator on 07/01/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 07/01/15. Actual NFPA Standard: Reference: NFPA 80A (1999 edition) 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 104	Maintenance Department on guidelines for smoke damper inspections on 7/6/15. On 7/2/15 the Quality Assurance Coordinator implemented an audit on the smoke damper inspections to insure that they were done every 4 years. This will be part of the facility Quality Assurance program and will be done by the Maintenance Department.	7/28/2015
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	K-144 Ed Cabbage Maintenance	

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K 144	Continued From page 16 This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, all residents, staff and visitors. The facility has the capacity for seventy-two (72) beds with a census of sixty-four (64) on the day of the survey. The findings include: Generator documentation review, on 07/01/15 at 2:00 PM, with the Maintenance Supervisor revealed the facility did not have weekly documentation for the generator or that the battery electrolyte levels were checked weekly. The last documented weekly check was in 05/2014. Interview, on 07/01/15 at 2:01 PM, with the Maintenance Supervisor revealed the weekly generator checks had been reassigned from Maintenance to the facility Electrician around 05/2014. Further interview revealed he was not aware of the location of the Electricians generator testing records. The census of sixty-four (64) was verified by the Administrator on 07/01/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 07/01/15. Actual NFPA Standard:	K 144	Supervisor performed a weekly generator check on 7/2/15. There were no problems noted Ed Cabbage Maintenance Supervisor checked to see if there were any other audits that were done that needed to be done by the Maintenance Department. Joey Vance NHA in-serviced the Maintenance Department on 7/6/15 on the importance of completing audits to include those on the generator on a timely basis. The Quality Assurance Coordinator implemented an audit on the weekly generator checks to include but not limited to time to start, cool down, etc. This audit will be done every week and will be done by the Maintenance Department. This will be part of the facility's Quality Assurance program	7/28/2015	

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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 07/01/2015
NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 805 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 144	Continued From page 17 Reference: NFPA 110 (1999 Edition). 6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. 6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.	K 144		