

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

PRINTED: 04/18/2014
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 C 04/04/2014
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 #KY21476 was conducted on 04/03/14 through 04/04/14 to determine the facility's compliance with Federal requirements. #KY21476 was substantiated with deficiencies cited at the highest S/S of an "E".	F 000	PLAN OF CORRECTION GRAYSON MANOR NURSING HOME SURVEY COMPLETION DATE OF April 04, 2014		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility policy, the facility failed to implement policies and procedures that prohibit mistreatment of residents by one (1) of three (3) sampled residents (Resident #2). The facility assessed Resident #2 as having a history of Combative Behavior with other residents and developed interventions to keep Resident #2 out of arm's reach of other residents, however, on 03/14/14 at 3:30 AM, CNA #3 left Resident #2 at the nurse's station on the hallway in his/her wheelchair and went into the nurse's station. Resident #1 walked by Resident #2 and Resident #2 hit Resident #1 in the chest and grabbed his/her wrist. Resident #1 sustained a pink blanchable area to the chest. The findings include:	F 224	Resident #1 was separated from resident #2 immediately. CNA #3 was put on Administrative leave on March 14, 2014 pending Investigation. CNA #3 was terminated from employment on March 20, 2014 for not following the Nurse aide care plan on March 14, 2014 regarding resident #2 who was care planned to be kept at arms-length away from other residents when in hallway. Social Services Director audited all residents for behaviors and reconciled that audit with current Interdisciplinary Care Plans and the nurse aide care plans on the kiosk. Findings were reconciled with RAI	5/15/2014	

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

TITLE

(X6) DATE

Joseph B. Vance

Administrator

April 22, 2014

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 224	Continued From page 1 Review of the facility's Behavior Management policy, last revised 02/12/12, revealed the Interdisciplinary Care Plan lists goals and interventions related to individualized behavior issues of specific residents. The care plan identified individualized interventions to be completed by all disciplines for specific residents. Review of the facility's Unmanageable Residents' policy, (not dated), revealed each resident will be provided with a safe place of residence. Record review revealed Resident #2 was readmitted to the facility on 12/19/13 with diagnoses which included Dementia unspecified without Behavioral Disturbance, Intermittent Explosive Disorder, and Unspecified Intellectual Disabilities. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 01/29/14, revealed the facility assessed Resident #2's cognition as severely impaired with a Brief Interview of Mental Status (BIMs) score of "4". Review of the Nurse's Notes, dated 01/26/14 at 7:00 AM, revealed Resident #2 was in his/her wheelchair on the hallway outside of the kitchen, when he/she kicked another resident on both shins causing skin tears. Review of Resident #2's Comprehensive Care Plan for At risk for Combative or Socially Inappropriate Behavior, dated 01/24/14, revealed interventions that if resident is combative with another resident remove other resident from harm and remove any other residents who may be harmed; if resident becomes agitated, take to nurses station to be closely monitored, start 30 minute watch and notify psych; and when take	F 224	Nurses to ensure residents with behaviors have appropriate interventions. The Nursing Personnel Director left a kiosk message to all Nursing staff to alert staff that residents with behaviors may have interventions updated daily on the Nurse Aide care plan on the kiosk that will require acknowledgement. On April 28, 2014 all staff was in-serviced by the Staff Development Coordinator regarding the importance of reading each residents Nurse Aide Care Plan on the kiosk prior to doing resident care. RAI Nurses perform in-service once a year for all nursing staff regarding the importance of reading each resident's Nurse Aide Care Plan on the kiosk. An audit conducted by the RAI Nurse's on all residents to ensure the Nurse Aide Care Plan on the		

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F 224	<p>Continued From page 2</p> <p>resident to dining room to monitor closely then take straight back to room; do not leave unattended in common areas or hall. Review of the CNA care plan, with intervention in place as of 02/07/14 stating Resident #2 should be kept at arms length away from other residents when in hallway.</p> <p>Review of Nurses' Notes, dated 03/13/14 at 3:30 AM, revealed Resident #2 was in the hallway at the nurse's station in his/her wheelchair when another resident (Resident #1) walked past him/her and he/she hit the resident in the chest and grabbed the resident's wrist.</p> <p>Interview with Certified Nurse Aide (CNA) #3, on 04/03/14 at 2:03 PM, revealed she had sat Resident #2 at the nurses station and walked around to go into the nurses station when another CNA hollered for Resident #2 to stop and she saw Resident #2 hitting Resident #1. CNA #3 stated she had not looked at Resident #2's stated she was aware of Resident #2's history but she thought Resident #2 just had to be watched. She was not aware Resident #2 was not supposed to be within arm's length of another resident when on the hall.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 04/04/14 at 11:18 AM, revealed due to Resident #2's history, Resident #2 should not have been left in reaching distance of another resident.</p> <p>Interview with LPN #4, on 04/04/14 at 1:30 PM, revealed she expected the care plans to be followed for the benefit of the residents safety and health. LPN #4 stated the CNA care plans include intervention to keep resident's safe and</p>	F 224	kiosk corresponds with the resident's current behaviors has been completed. The audits will be completed weekly for 4 weeks and then monthly until 100% compliance is achieved and then quarterly. This audit will be conducted as part of the Facility's Quality Assurance Program.		

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F 224	Continued From page 3 the interventions should be implemented. Interviews with CNA #1, CNA #7, CNA #8 and CNA #9, on 04/14/14 at 2:01 PM, 2:10 PM, 2:19 PM and 2:20 PM, revealed they were taught to look at the nurse aide care plans to know what interventions were in place to ensure resident's safety. CNA #9 stated Resident #2 should be provided space because he/she does not like anyone getting in his/her space. Interview with the Director of Nursing (DON), on 04/03/14 at 11:01 AM and on 04/04/14 at 9:19 AM, revealed the nursing care plan drives the CNA care plan. The DON stated she expected the care plans for residents to be followed, and the CNA care plans for the residents are on the kiosk.	F 224			
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to allow the residents to make choices about aspects of their life that was significant to the resident. On 04/03/14 at 03:20 AM, six (6) unsampled residents (Resident A, B, C, D, E,	F 242	F242 An voice message over the phone system was left for all Charge Nurse's by the Director of Nursing on April 4, 2014 stating that residents who eat in Churchill dining room are not to be gotten up for breakfast prior to 4:30 am. On April 25, 2014 an audit related to residents actual time getting up for	5/15/2014	

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F 242	<p>Continued From page 4 and F) were observed to be up dressed in their wheelchairs in the hallway.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Bill of Rights", (not dated) revealed all residents shall be encouraged and assisted throughout their period of stay in long-term care facilities to exercise their rights as a resident and a citizen, and to this end may voice grievances and recommend change in policies and services to facility and staff and to outside representation of their choice, free from restraint, interference, coercion, discrimination, or reprisal. Each resident shall be treated with consideration, respect, and full recognition of his dignity and individually, including privacy in treatment and care for his personal needs.</p> <p>Observation during the tour of the facility, on 04/03/14 at 3:20 AM, revealed six (6) residents (Resident A-F) were sitting in their wheelchairs on the hallway. Resident A, B, C, and D had their eyes closed.</p> <p>Further observation, on 04/03/14 at 3:58 AM, revealed Resident G was in his/her room sitting in a wheelchair. Interview with Resident G, who was a facility identified interviewable resident, revealed the staff get him/her up early and she did not like to get up early.</p> <p>Interview with Resident H who was a facility identified interviewable resident, on 04/04/14 at 10:30 AM, revealed staff got him/her up real early in the morning. The resident stated he/she asked staff why they get him/her up so early and the staff stated they had a routine to follow. Resident H revealed staff get him/her up in the chair three</p>	F 242	<p>breakfast has been completed by the staff Development Coordinator. On April 25, 2014 an audit interviewing all residents related to preferences for a.m. waking routine for breakfast has been completed by Social Services.</p> <p>On April 28, 2014 all staff was in-serviced by the staff Development Coordinator regarding residents who eat in Churchill dining room are not to be gotten up for breakfast prior to 4:30 am. All new admissions will be screened upon admission by the Charge Nurse for preferences for a.m. waking routine and reported to dietary.</p> <p>An audit related to residents actual time getting up for breakfast has been completed by the staff Development Coordinator on April 25, 2014. The audits will be completed weekly for 4 weeks and then monthly until 100% compliance</p>		

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F 242	<p>Continued From page 5</p> <p>(3) to four (4) hours before his/her therapy is scheduled and the chair gets hard. The resident stated his/her therapy was at 9:00 AM.</p> <p>Interview with Certified Nurse Aide (CNA) #1 and CNA #4, on 04/03/14 at 3:25 AM and 4:10 AM, revealed they came in at 3:00 AM and helped get the residents up.</p> <p>Interview with CNA #5, on 04/03/14 at 4:15 AM, revealed she assisted residents up that morning and staff try to have all the residents up by 6:00 AM, and usually start around 3:30 AM. CNA #5 stated they started earlier today because a CNA had left at 3:00 AM.</p> <p>Interview with CNA #2, on 04/03/14 at 4:50 AM, revealed staff start getting a group of fifteen (15) residents on wing one (1) and sixteen (16) residents on wing two (2) up at 3:00 AM so they are all up by 6:00 AM for breakfast.</p> <p>Interview with CNA #3, on 04/03/14 at 2:03 PM, revealed she helped get residents up at 3:00 AM that morning. The CNA stated some of the residents don't want to get up but we have no choice, the nurses tell us we have to get them up.</p> <p>Interview with CNA #6, on 04/03/14 at 8:15 AM, revealed her and another CNA usually started getting up around twenty (20) residents at 3:00 AM.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 04/03/14 at 7:28 AM, revealed the aides start getting the residents up between 3:00 AM and 4:00 AM because they have to have all the residents up for breakfast by 6:00 AM. The LPN stated staff get up about twenty-five (25)</p>	F 242	<p>is achieved and then quarterly. This audit will be conducted as part of the facilities Quality Assurance Program. An audit related to preferences for a.m. waking routine for breakfast will be conducted by the Dietary Supervisor on all new admissions weekly for 4 weeks and then monthly until 100% compliance is achieved and then quarterly. This audit will be conducted as part of the facilities Quality Assurance Program.</p>		

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F 242	Continued From page 6 residents on Skilled II Hall between 3:00 AM and 6:00 AM. Interview with LPN #3, on 04/03/14 at 08:40 AM, revealed they start getting up resident at 03:30 AM, and try to have them all up by 06:00 AM on Skilled I hall. Interview with LPN #4, on 04/04/14 at 1:30 PM, revealed they have to have all the residents up by 6:00 AM and only have 2 aides on each hall and it took 2 aides to get most of the resident up. Interview Director of Nursing (DON), on 04/04/14 at 3:30 PM, revealed some residents are up all night and some like to get up early and some don't. The DON stated the residents that don't want to get up early can eat in their rooms. The DON revealed she liked for them to get up closer to 4:00 AM but she thought they try to get the residents up between 3:30 AM and 4:00 AM. Interview with the Administrator, on 04/04/14 at 3:51 PM, revealed 3:30 AM sounded too early to get someone up for breakfast and he would say 4:30-5:00 AM would be a reasonable hour to get residents up. The Administrator revealed breakfast was served at 6:00 AM in one dining room and at 6:30 AM in the other dining room.	F 242			
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.	F 282	F282 Resident #1 was separated from resident #2 immediately. CNA #3 was put on Administrative leave on March 14, 2014 pending	5/15/2014	

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F 282	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview, and review of the facility policy, the facility failed to implement the plan of care for one (1) of three (3) sampled residents (Resident #2). The facility failed to ensure Resident #2 was not in arms reach of another resident per care plan. Resident #2 was left unattended in the hallway, and when Resident #1 walked by Resident #2, Resident #2 hit Resident #1's chest and grabbed his/her wrist.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 04/03/14 at 11:10 AM, revealed the facility follows the guidelines in the Resident Assessment Instrument User Manual. The manual states the facility "develops and implements an interdisciplinary care plan based on the complete assessment information gathered by the RAI process, with necessary monitoring and follow-up". Daily care needs that are specific to the resident and are out of the ordinary must be addressed on the care plan.</p> <p>Record review revealed Resident #2 was readmitted to the facility on 12/19/13 with diagnoses which included Dementia unspecified without Behavioral Disturbance, Intermittent Explosive Disorder, and Unspecified Intellectual Disabilities. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 01/29/14, revealed the facility assessed Resident #2's cognition as severely impaired with a Brief Interview of Mental Status (BIMs) score of "4". Further review revealed the resident had no behaviors during this assessment period.</p>	F 282	<p>Investigation. CNA #3 was terminated from employment on March 20, 2014 for not following the Nurse aide care plan on March 14, 2014 regarding resident #2 who was care planned to be kept at arms-length away from other residents when in hallway.</p> <p>Social Services Director audited all residents for behaviors and reconciled that audit with current Interdisciplinary Care Plans and the nurse aide care plans on the kiosk. Findings were reconciled with RAI Nurses to ensure residents with behaviors have appropriate interventions. The Nursing Personnel Director left a kiosk message to all Nursing staff to alert staff that residents with behaviors may have interventions updated daily on the Nurse Aide care plan on the kiosk that will require acknowledgement.</p>		

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F 282	<p>Continued From page 8</p> <p>Review of Resident #2's Comprehensive Care Plan for At risk for Combative or Socially Inappropriate Behavior, dated 01/24/14, revealed interventions that if resident is combative with another resident remove other resident from harm and remove any other residents who may be harmed; if resident becomes agitated, take to nurses station to be closely monitored, start 30 minute watch and notify psych; and when take resident to dining room to monitor closely then take straight back to room; do not leave unattended in common areas or hall. Review of the CNA care plan, with intervention in place as of 02/07/14 stating Resident #2 was to be kept at arms length away from other residents.</p> <p>Review of Nurses' Notes, dated 03/13/14 at 3:30 AM, revealed Resident #2 was in the hallway at the nurse's station in his/her wheelchair when another resident (Resident #1) walked past him/her and he/she hit the resident in the chest and grabbed the resident's wrist.</p> <p>Interview with Certified Nurse Aide (CNA) #3, on 04/03/14 at 2:03 PM, revealed she had sat Resident #2 at the nurses station and walked around to go into the nurses station when another CNA hollered for Resident #2 to stop and she saw Resident #2 hitting Resident #1. CNA #3 stated she had not looked at Resident#2's care plan and she did not know that she had to keep Resident #2 at least an arm length away from other residents. She stated she thought Resident #2 just had to be watched.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 04/04/14 at 11:18 AM, revealed the resident was care planned not to be left unattended around other residents at all. The LPN stated</p>	F 282	<p>On April 28, 2014 all staff was in-serviced by the Staff Development Coordinator regarding the importance of reading each residents Nurse Aide Care Plan on the kiosk prior to doing resident care. RAI Nurses perform in-service once a year for all nursing staff regarding the importance of reading each resident's Nurse Aide Care Plan on the kiosk.</p> <p>An audit conducted by the RAI Nurse's on all residents to ensure the Nurse Aide Care Plan on the kiosk corresponds with the resident's current behaviors has been completed. The audits will be completed weekly for 4 weeks and then monthly until 100% compliance is achieved and then quarterly. This audit will be conducted as part of the Facility's Quality Assurance Program.</p>		

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F 282	<p>Continued From page 9</p> <p>Resident #2 should not have been left in reaching distance of another resident.</p> <p>Interview with LPN #4, on 04/04/14 at 1:30 PM, revealed she expected the care plans to be followed for the benefit of the residents safety and health. LPN #4 stated the CNA care plans are in the kiosk (computer) for the CNAs to follow.</p> <p>Interviews with CNA #1, CNA #7, CNA #8 and CNA #9, on 04/14/14 at 2:01 PM, 2:10 PM, 2:19 PM and 2:20 PM, revealed they were taught to follow the nurse aide care plan and knew how to care for the residents because their care plans were in the kiosk. CNA #9 stated Resident #2 should be provided space because he/she does not like anyone getting in his/her space.</p> <p>Interview with the Director of Nursing (DON), on 04/03/14 at 11:01 AM and on 04/04/14 at 9:19 AM, revealed the nursing care plan drives the CNA care plan. The DON stated she expected the care plans for residents to be followed, and the CNA care plans for the residents are on the kiosk.</p>	F 282		