

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

STATEMENT OF DEFICIENCIES
 PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
 IDENTIFICATION NUMBER:

185248

(X2) MULTIPLE CONSTRUCTION
 A. BUILDING **01 - MAIN BUILDING 01**
 B. WING _____

(X3) DATE SURVEY
 COMPLETED

C
08/12/2011

NAME OF PROVIDER OR SUPPLIER

SAYRE CHRISTIAN VILLAGE NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
**3840 CAMELOT DRIVE
 LEXINGTON, KY 40517**

(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)

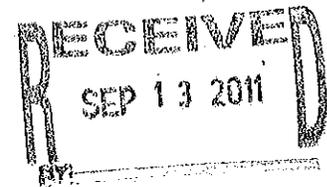
(X6)
 COMPLETION
 DATE

K 000

INITIAL COMMENTS

 CFR: 42 CFR 483.70(a)
 Building: 01
 Plan Approval: 1991
 Survey under: 2000 existing
 Facility type: SNF/NF
 Type of structure: One (1) story Type V111.
 Smoke Compartment: Four (4) smoke
 compartments
 Fire Alarm: Complete fire alarm system.
 Sprinkler System: Complete automatic sprinkler
 system.
 Generator: Type II
 An abbreviated Life Safety Code survey was
 conducted on 08/11/2011. Sayre Christian Village
 Nursing Home was found not to be in compliance
 with the requirements for participation in
 Medicare and Medicaid. The census the day of
 the survey was one hundred nine (109). The
 facility is licensed for one hundred nine (109)
 residents.
 The findings that follow demonstrate
 noncompliance with Title 42, Code of Federal
 Regulations, 483.70(a) et seq. (Life Safety from
 Fire)

K 000



Preparation and execution of this plan of
 correction does not constitute an admission
 of or agreement by the provider of the truth
 of the facts alleged or conclusions set forth
 in the statement of deficiency. This Plan of
 Correction is prepared and executed solely
 because Federal and State Law require it.
 Compliance has been and will be achieved
 no later than the last completion date
 identified in the POC. Compliance will be
 maintained as provided in the Plan of
 Correction. Failure to dispute or challenge
 the alleged deficiencies below is not an
 admission that the alleged facts occurred as
 presented in the statements.

K 038
 88=E

NFPA 101 LIFE SAFETY CODE STANDARD

 Exit access is arranged so that exits are readily
 accessible at all times in accordance with section
 7.1. 19.2.1

K 038

K038
NFPA 101 LIFE SAFETY CODE
STANDARD

Targeted Residents
 No Residents were directly affected by this
 practice although facility realizes that there was a
 potential to affect 109 residents and 144 staff
 members and visitors by removal of sidewalk on
 8-8-11. On 8-10-11 the facility removed door # 4
 as an operable exit by placing board on door,
 locking door and placing a sign redirecting staff,

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

[Handwritten Signature]

TITLE
Administration

(X6) DATE
9/13/11

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 SAYRE CHRISTIAN VILLAGE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3840 CAMELOT DRIVE LEXINGTON, KY 40517
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K 038	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exits according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of eight (8) emergency exits, one hundred and nine (109) residents, one hundred and forty one (141) staff, and visitors.</p> <p>The findings include:</p> <p>Observation, on 08/11/11 at 1:22 PM, with the Maintenance Director and the Owner Representative of Construction, revealed exits two (2), three (3), and four (4) did not terminate at the Public Way. The side walk leading from exits two (2) and three (3) terminated into a gravel lot that construction was preparing to blacktop. Exit two (2) was the only means of exit for residents located on the D Hall. Exit four (4) at this time was closed off and was not being used as an exit. Exits must terminate at a public way (road or sidewalk) leading away from the building.</p> <p>Interview, on 08/11/11 at 1:22 PM, with the Owner Representative of Construction, revealed the sidewalk leading from exits two (2), three (3) and four (4) did terminate at the public way before construction began on the area. Further interview revealed construction began on 08/08/11 at 12:00 PM, and at this time the sidewalk was removed. Exit four (4) was closed off as an exit after a representative from the Office of Inspector General (OIG) questioned the exits.</p> <p>Interview, on 08/11/11 at 3:21 PM, with the Director of Nursing (DON), revealed the construction company was to notify the facility if</p>	K 038	<p>residents, and visitors to exit door #7 for emergency evacuation. 24-7 monitors were placed at doors #2 and #3 to ensure no residents could exit the door and in the event of an emergency evacuation a sign was also posted on doors #2 and #3 re-routing anyone to a grassy area outside the facility and directing door #4 evacuation to door #7. Effective August 12, 2011 a sidewalk was reinstalled which allowed for required egress from doors #2, #3, #4 to a paved way at 3:00 p.m. An in-service was held by the Director of Nursing, Assistant Director of Nursing, and the Weekend House Supervisor on August 10-August 15th to all staff regarding temporary evacuation route.</p> <p>Identification of Other Residents All 109 residents had the potential to be affected by this practice.</p> <p>Systemic Changes The Director of Housing began meeting with the Construction Manger on a weekly basis effective August 15, 2011 to get weekly updates regarding construction plans for the week. The Director of Housing began meeting weekly with the Administrator to update on any construction plans for the week. In absence of the Director of Housing the Administrator will meet weekly with the Construction Manager. The Lead Maintenance Technician, the Director of Nursing and the Administrator will be checking each exit daily to ensure proper egress is being obtained and will notify staff of these changes when needed. The charge nurse will also be checking each exit door every shift Sunday-Saturday to ensure facility's security system is functioning properly. Any issues identified from these rounds will be brought to the Administrator's and or Director of Nursing's attention immediately and</p>	
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K 038 Continued From page 2
construction was going to affect any exits. Further interview revealed the facility had not been contacted by the construction company of any exits being affected by construction.

Interview, on 08/11/11 at 3:23 PM, with the Owner Representative of Construction, revealed he was responsible for contacting the facility if exits were affected by construction.

Interview, on 08/12/11 at 2:24 PM, with the Owner Representative of Construction, revealed he thought the area the sidewalks lead to, the graveled area, met the requirements for exits terminating at a public way.

Interview, on 08/12/11 at 6:45 PM, with the Administrator confirmed the findings, resident numbers and staff numbers.

K 048 SS=F NFPA 101 LIFE SAFETY CODE STANDARD

There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1

This STANDARD is not met as evidenced by: Based on observation, interview and staff training records it was determined the facility failed to ensure staff were trained in the proper emergency procedures in case of fire or other emergency(ies) according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, one hundred nine (109) residents, one hundred forty four (144) staff, and visitors.

K 038 will also be discussed in the daily M-P Continuous Quality Improvement Meeting that all Department Heads attend.

A Life Safety Team which consists of the Administrator, Director of Nursing, the Lead Maintenance Technician, a representative from nursing, housekeeping, Social Services, Dietary, and Activities was formed and met on Friday August 26th and Friday September 2nd to address all Life Safety/ Environmental concerns. They revised and approved the facility's Fire and Disaster Books and they were placed at each nurse's station, in Maintenance Office, in Administrator and Director of Nursing Office, Laundry and in Dietary on August 26, 2011. The Life Safety Team will be meeting weekly starting August 26th- September 16th. They will then go
Cont. on pg 3.1 of 6

K 048 K048
NFPA 101 LIFE SAFETY CODE
STANDARD

Targeted Residents
No Residents were directly affected by this practice although facility realizes that there was a potential to affect 109 residents and 144 staff members and visitors by removal of sidewalk on 8-8-11. On 8-10-11 the facility removed door # 4 as an operable exit by removing the exit sign, placing board on door, locking door and placing a sign redirecting staff, residents, and visitors to exit door #7 for emergency evacuation. 24-7 monitors were placed at doors #2 and #3 to ensure no residents could exit the door and in the event of an emergency evacuation a sign was also posted on doors #2 and #3 re-routing anyone to a grassy area outside the facility and directing

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER SAYRE CHRISTIAN VILLAGE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3840 CAMELOT DRIVE LEXINGTON, KY 40517
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			<p>to monthly meetings. The Life Safety committee set-up a drill calendar for the next 12 months to include, fire drills, evacuation drills, elopement drills and tornado drills.</p> <p>An all staff in-service was given to all staff on the Fire and Disaster Programs for the facility by the Assistant Director of Nursing and Weekend House Supervisor beginning 8/27/11 and completed 9/6/11.</p> <p>Monitoring Any issues/concerns found through all of the above mentioned rounds will be brought to the Quality Assurance Committee meetings which will be held monthly for 3 months to ensure that facility is in compliance with K038 and that the plan in place is effective.</p>	09/20/11
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K 048

Continued From page 3

The findings include:

Observation, on 08/11/11 at 1:22 PM, with the Maintenance Director and the Owner Representative of Construction, revealed exits two (2), three (3), and four (4) did not terminate at the Public Way. The side walk leading from exit two (2) and three (3) terminated into a gravel lot that construction was preparing to blacktop. Exit two (2) was the only means of exit for residents located on the D Hall. Exit four (4), at this time, was closed off and was not being used as an exit. Exits must terminate at a public way (road or sidewalk) leading away from the building.

Interview, on 08/11/11 at 1:22 PM, with the Owner Representative of Construction, revealed the sidewalk leading from exits two (2), three (3) and four (4) did terminate at the public way before construction began on the area. Further interview revealed construction began on 08/08/11 at 12:00 PM, and at this time the sidewalk was removed. Exit four (4) was closed off as an exit after a representative from the Office of Inspector General (OIG) questioned the exits.

Interview, on 08/11/11 at 3:30 PM, with the Director of Nursing, revealed staff were not educated on exits being affected by construction at the facility until 08/10/11, two (2) days after the exits were affected by the construction.

Reference: NFPA 101 (2000 edition)
 10.7.2 Procedure in Case of Fire.
 10.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective

K 048

door #4 evacuation to door #7. All staff was trained by the Director of Nursing, Assistant Director of Nursing and the Weekend House Supervisor from 8-10-11 thru 8-15-11 regarding temporary evacuation procedures. Any new staff was trained and will be trained upon hire by either the HR representative or the Assistant Director of Nursing or House Supervisor prior to working the floor in orientation. Effective August 12, 2011 a sidewalk was reinstalled which allowed for required egress from doors #2, #3 and #4 at 3:00 p.m.

Identification of Other Residents
 All 109 residents had the potential to be affected by this practice.

Systemic Changes
 The Director of Housing began meeting with the Construction Manger on a weekly basis effective August 15, 2011 to get weekly updates regarding construction plans for the week. The Director of Housing began meeting weekly with the Administrator on August 15, 2011 to update on any construction plans for the week. In absence of the Director of Housing the Administrator will meet weekly with the Construction Manager. The Lead Maintenance Technician, the Director of Nursing and the Administrator will be checking each exit daily to ensure proper egress is being obtained effective August 15, 2011 M-F and will notify staff of these changes when needed. The charge nurse will also be checking each exit door every shift beginning August 15, 2011 Sunday-Saturday to ensure facilities security system is functioning properly. Any issues identified will be brought to the Administrator's and or Director of Nursing's attention immediately and will also be discussed

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K 048	<p>Continued From page 4</p> <p>response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy's fire safety plan.</p> <p>19.7.2.2 A written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>19.7.2.3 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions:</p> <ol style="list-style-type: none"> (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm 	K 048	<p>in the daily M-F Continuous Quality Improvement Meeting effective August 15, 2011 that all Department Heads attend.</p> <p>A Life Safety Team which consists of the Administrator, Director of Nursing, the Lead Maintenance Technician, a representative from nursing, housekeeping, Social Services, Dietary, and Activities was formed and met on Friday August 26th and Friday September the 2nd to address all Life Safety/ Environmental concerns. They revised and approved the facility's Fire and Disaster Books and they were placed at each nurse's station, in Maintenance Office, in Administrator and Director of Nursing Office, in Laundry and Dietary on August 26, 2011. The revised Fire and Disaster Book includes (1) use of alarm, (2) Transmission of alarm to fire department, (3) Response to alarms, (4) Isolation of fire, (5) Evacuation of immediate area, (6) Evacuation of Smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire. The Life Safety Team will be meeting weekly starting August 26th- September 16th. They will then go to monthly meetings. The Life Safety committee set-up a drill calendar for the next 12 months to include, fire drills, evacuation drills, elopement drills and tornado drills.</p> <p>An all staff in-service was given to all staff on the Fire and Disaster Programs for the facility by the Assistant Director of Nursing and Weekend House Supervisor beginning 8/27/11, and completed 9/6/11. The in-service held contained (1) When the individual who discovers the fire must immediately go to aid of the endangered person, (2) during a malfunction of the building fire alarm system personnel hearing the code announced first shall activate the building fire</p>	
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K 048

Continued From page 5.
system
Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and then shall execute immediately their duties as outlined in the fire safety plan.
19.7.3 Maintenance of Exits. Proper maintenance shall be provided to ensure the dependability of the method of evacuation selected. Health care occupancies that find it necessary to look exits shall, at all times, maintain an adequate staff qualified to release locks and direct occupants from the immediate danger area to a place of safety in case of fire or other emergency.

K 048

alarm using the nearest manual fire alarm box and then shall execute immediately their duties as outlined in the fire safety plan. The facility conducted fire drills by a Life Safety Committee member(s) to further help educate staff on fire/disaster/elopement procedures. Fire Drills were conducted on 8/26/11 at 4:30 p.m., 8/27/11 at 12:45 a.m., at 8/27/11 at 10:00 a.m., at 8/27/11 at 8:33 p.m., and at 8/31/11 at 9:25 a.m. Tornado drills were conducted at 8-29-11 at 3:45 p.m., 8-30-11 at 2:29 p.m. and 8-30-11 at 2:10 p.m. Elopement drills were conducted on 8/27/11 at 2:50 p.m., 8/29/11 at 1:55 p.m. and on 8/31/11 at 4:08 p.m. by Social Services. All new staff will be in-serviced on Fire and Disaster Program in orientation.

Monitoring

The Life Safety Code Team will bring any concerns found during drill(s) to the Safety Team to monitor for educational needs, etc. Any issues/concerns found through the above mentioned rounds will be brought to the Quality Assurance Committee which will be held monthly for 3 months to ensure that facility is in compliance with K048 and that plan in place is effective.

09/20/11