

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

PRINTED: 03/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185248	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/08/2013
NAME OF PROVIDER OR SUPPLIER  SAYRE CHRISTIAN VILLAGE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3775 BELLEAU WOOD 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)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  A Recertification Survey was conducted 03/05/13 through 03/08/13. A Deficiency was cited with a Scope and Severity of an "E".	F 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.		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens	F 441	<u>F 144 Infection Control</u>  Corrective Action for Targeted Residents The Licensed staff members, RN #1 and RN#2 found to not be practicing appropriate hand hygiene before and after each resident during medication administration and after changing gloves while performing accu-checks was re-educated by the Assistant Director of Nursing on March 6, 2013 and March 8, 2013 respectively. She reviewed the facility's policy on "Handwashing / Hand Hygiene" which includes before and after direct resident contact and after removing gloves.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X8) DATE 3/26/13

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 441	<p>Continued From page 1</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for five (5) Unsampled Residents (Unsampled Residents A, B, C, D, and E).</p> <p>Observation of an accucheck for a fingerstick blood sugar revealed the nurse performed the fingerstick on Unsampled Resident A, removed her soiled gloves and failed to wash her hands prior to exiting the room.</p> <p>Further observation revealed a nurse administered medications to Unsampled Resident B and exited the room without washing or sanitizing her hands. The nurse then set up medications for Unsampled Resident C, sanitized her hands prior to medication administration and administered medications to Unsampled Resident C. The nurse then exited Unsampled Resident C's room without washing or sanitizing her hands. The nurse then set up and administered medication to Unsampled D, and exited the room without washing or sanitizing her hands and immediately started setting up medications for Unsampled Resident E.</p>	F 441	<p><b>Identification of Other Residents with Potential to be affected</b></p> <p>All residents have the potential to be affected. A review of the facilities Infection Control Program's tracking and trending report was completed by the Assistant Director of Nursing on March 21, 2013 to identify any further breach of standard infection control practice. There were no other residents identified through this process.</p> <p><b>Systemic changes</b></p> <p>The Director of Nursing reviewed the facilities Infection Control Policy on March 20, 2013 to ensure that it met the general infection control standards to prevent the spread of infection within the facility including management and surveillance of infections as they occur and for adequate training of all staff. Review of the policies indicates that they are satisfactory to meet the requirements.</p> <p>An inservice for the facility's staff was presented beginning March 13, 2013 through March 23, 2013 by the Director of Nursing and Assistant Director of Nursing to re-educate on standard infection control practices and the facility's Infection Control Policy. This inservice included review of the policy</p>	

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F 441 Continued From page 2

The findings include:

Review of the facility Handwashing/Hand Hygiene Policy, undated, revealed employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water before and after performing any invasive procedure (e.g. fingerstick blood sampling). Further review, revealed if hands are not visibly soiled use an alcohol based hand rub containing 60-95% ethanol or isopropanol before preparing or handling medications.

1. Observation of an accucheck for a fingerstick blood sugar, on 03/05/13 at 4:30 PM, of the 300 Unit for Unsampled Resident A revealed Registered Nurse (RN) #1 performed the fingerstick, removed her soiled gloves and exited the room without washing or sanitizing her hands. RN #1 then cleaned the glucometer machine with a Sanicloth Bleach Wipe and placed it back on the medication cart, and pushed the medication cart down the hall.

Interview with RN #1 immediately after the fingerstick as she was pushing the medication cart down the hall revealed she had not washed her hands.

2. Observation of medication pass, on 03/07/13 from 8:30 AM to 9:00 AM, on the 200 Unit revealed RN #2 administered medications to Unsampled Resident B by handing the resident the cup of pill and a glass of water and exited the room without washing or sanitizing her hands. RN #2 then set up medications for Unsampled Resident C by placing medications in a medicine

F 441 on the standard practice of hand hygiene.

Staff was also required to successfully pass an exam on acceptable infection control practices following the inservice to ensure comprehension and future compliance with this policy.

During new employee orientation, newly hired nursing staff will receive education by the Staff Development Coordinator on standard infection control practices regarding hand hygiene and the facilities Infection Control Policy. They will also be required to return demonstrate satisfactory handwashing technique before receiving assignment to floor orientation.

**Monitoring**

The Director of Nursing, Assistant Director of Nursing and other assigned Nursing Managers will complete audits to ensure staff are practicing appropriate hand hygiene during medication pass, accu-check monitoring, and other random tasks that require handwashing for prevention of infection transmission. These audits will occur daily x 2 weeks, then weekly x 4 weeks, then again in 2 weeks and then in 1 month.

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F 441 Continued From page 3  
cup with applesauce, then sanitized her hands and administered medications to Unsampled Resident C by spoon feeding the pills whole with applesauce. RN #2 then exited Unsampled Resident C's room without washing or sanitizing her hands. Further observation revealed RN #2 then set up Unsampled Resident D's medications and administered the medications whole by spoon feeding the medications from a medicine cup. RN #2 then exited Unsampled Resident D's room without washing or sanitizing her hands. RN #1 began to set up medications for Unsampled Resident E.

Interview, on 03/07/13 at 9:00 AM, with RN #2, revealed she should have washed her hands or sanitized her hands before and after medication administration.

Interview, on 03/08/13 at 3:40 PM, with the Assistant Director of Nursing (ADON)/Infection Control Nurse revealed staff should wash hands after a fingerstick, as well as wash or sanitize hands before and after medication administration and between residents.

F 441 Infection Control Rounds will be completed by the Assistant Director of Nursing to ensure all other infection control practices are adequate to prevent the spread of infection. These rounds will occur weekly x 4 weeks, then every 2 weeks x 4 weeks, then monthly x 1 month.

Any non-compliance found during the audits or rounds will require immediate corrective action by the Director of Nursing or other member of nursing management as deemed appropriate by facility Administration.

Results of the audits and rounds will be submitted to the Quality Assurance committee for review and revision until the Quality Assurance committee has determined 100% compliance has been achieved.

3/26/13

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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  Building: 01  Plan Approval: 1982  Survey under: NFPA 101 (2000 Edition), Chapter 19 (existing health care)  Facility type: SNF/NF  Smoke Compartment: 5  Fire Alarm: Complete fire alarm  Sprinkler System: Complete automatic sprinkler system	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 062 SS=D	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, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by:	K 062	Corrective Action for Targeted Residents No Residents were directly affected by this practice although the facility realizes that there was a potential to affect all residents, staff and visitors in this smoke compartment area located on Unit 2. On 3-19-2013 Central Kentucky Sprinkler replaced the two sprinkler heads identified with corrosion in Unit #2 shower room.  Identification of Other Residents with Potential to be affected All residents have the potential to be affected. An audit was performed by		

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MAR 26 2013  
BY: \_\_\_\_\_

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

*[Signature]*

TITLE

Administrator

(X6) DATE

3/26/13

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K 062 Continued From page 1

Based on observation and interview it was determined the facility failed to ensure sprinklers were free of corrosion for two (2) sprinklers.

The findings include:

Observation during tour of the facility, on 03/07/13 between 9:00 AM and 2:30 PM, revealed there was corrosion on two (2) sprinkler heads in Unit #2 shower room.

Interview with the Maintenance Director, on 03/07/13 at 12:24 PM, revealed he was not aware of the sprinkler heads being corroded and thought the contracted sprinkler company should have replaced the heads.

Reference: NFPA 25 (1998 Edition).

2-2.1.1\* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.

K 062 Maintenance on March 8, 2013. Maintenance found 2 sprinkler heads in outside courtyard and 2 sprinkler heads in Shower room on Unit #1 in need of being replaced due to corrosion. Central Kentucky Sprinkler replaced the above 4 sprinkler heads on 3-19-13.

**Systemic changes**

On March 8, 2013 the Maintenance Director in-serviced all Maintenance staff on K062 tag and reporting to him any issues found so they can be replaced. On March 11, 2013 the Administrator reviewed K062 tag with all Department Directors. The Department Directors were directed to report any sprinkler heads that were found with impediments during their daily M-F Continuous Quality Improvement Rounds to be reported to Maintenance Director immediately for replacement.

On March 14, 2013 the Safety Team called an impromptu meeting regarding LSC tag K062 to review requirement. The Safety team changed their rounds sheets to add checking of sprinkler heads for impediments.

On March 18-19, 2013 The Housekeeping Supervisor in-serviced all Housekeepers that their daily M-F cleaning sheets have been updated for

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K 062

K 062 them to observe sprinkler heads in their assigned areas and to report any issues found to Maintenance.

An in-service for all the facility's staff was presented beginning March 13, 2013 through March 23, 2013 by the Director of Nursing and Assistant Director of Nursing to include the tag K062 and reporting any findings regarding sprinkler heads found to not be free of corrosion, foreign materials, paint and physical damage to Maintenance immediately.

**Monitoring**

The Department Directors daily Continuous Quality Improvement M-F rounds will now include the reporting of issues with sprinkler heads and will reviewed daily M-F in the morning Department director Meeting. The housekeeping M-F cleaning rounds have also been updated to include sprinkler head concerns and will be reported immediately to Maintenance.

The Safety Team will perform weekly rounds for 4 weeks to monitor any issues with sprinkler heads and then will perform monthly rounds on-going after the 4 weeks.

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K 062		K 062	Results of the audits and rounds will be submitted to the Quality Assurance committee for review and revision until the Quality Assurance committee has determined 100% compliance has been achieved.	3/26/13
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