

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

PRINTED: 09/02/2011
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 C 08/19/2011
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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 40617
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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
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INITIAL COMMENTS

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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.

An Abbreviated/Partial Extended Survey Investigating KY#00016815 and KY#00016871 was conducted 08/10/11 through 08/18/11.

KY#00016815 and KY#00016871 were unsubstantiated with no deficiencies.

Unrelated deficiencies were identified and cited at a 8/S of an "E".

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88-E

483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

F 323

F323
Free of Accidents / 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.

Targeted Residents
While we realize that there is a remote potential for any resident to exit the facility, no residents were affected by this alleged deficient practice.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, review of the facility's Emergency Evacuation Plan, review of the facility's Evacuation Routes and review of the construction company's daily log it was determined the facility failed to ensure the residents' environment remained as free of accident hazards as possible; and each resident received adequate supervision to prevent accidents. The facility failed to ensure a safe evacuation plan by allowing staff, residents, and visitors to access the construction site outside the building, and failed to ensure barriers were in place to restrict resident access through the

Identification of other residents
All residents, staff and visitors have to potential to be affected by the alleged deficient practice. The facility has identified 27 residents as having a potential risk of elopement. The facilities "Elopement Risk" assessment is consistently completed upon admission, upon return from a hospitalization, quarterly and with a significant change in condition. For the purpose of the allegation, all residents received an additional "Elopement Risk" assessment to ensure no other residents have the potential to elope from the facility per the terms of this assessment tool. These additional assessments were completed by the Assistant Director of Nursing, Unit

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator 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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F 323 Continued From page 1
 facility's exits. The facility failed to assess and evaluate the Evacuation Plan to develop necessary changes in order to ensure safe exits were available after the facility began construction on 05/26/11, which altered the safety of the exits. The facility failed to ensure staff was trained and knowledgeable regarding which fire exits were unsafe for evacuation during construction.

The facility identified twenty-six (26) residents at risk for wandering and/or elopement. The Interim Maintenance Director explained the facility had no "Wanderguard" system (an alarm system where a transmitter is attached to the resident and receivers are mounted near the exit; the system is used to prevent unauthorized exit of residents) on exit doors #2, #3, #4, #7, #8 and #9. Doors #2, #3, #4, #7, #8 and #9 were equipped with panic bars which allowed the doors to open after fifteen (15) seconds. During the fifteen (15) seconds, the doors would alarm to alert staff that someone was exiting. Observation, on 08/10/11, revealed the alarms for the panic bars stopped sounding after someone exited and the door closed.

The findings include:

Review of the facility's Fire, Evacuation and Disaster Plan Summary, not dated, revealed staff was to evacuate residents to pre-assigned areas. Additionally, upon sounding of the fire alarm, all exits were to be inspected to ensure they were safe and passable. If the exit was not passable a secondary exit was to be used. If both the primary and secondary exits were blocked attempt to remove the obstruction from at least

F 323 Managers, MDS Coordinators, and the Restorative Nurse, and were completed on September 6, 2011. No other residents were identified.

In addition, all ordered safety devices including positioning devices, restraints and side rails were reviewed to ensure all were appropriately care planned and their use is effective for the residents' individual medical symptoms. These audits began August 16, 2011 and were completed August 22, 2011. These audits were completed by the Assistant Director of Nursing, Unit Managers, MDS Coordinators, Social Services Directors, and Restorative Nurse, and were completed on August 19, 2011.

Systemic changes
 An update to the facilities Emergency Evacuation Plan was completed on August 10, 2011 to address the emergency exit route for door #2 and #3 which temporarily evacuated to a grassy area outside the building. Exit from door #4 was directed through door #7 as its exit was temporarily removed from the Emergency Evacuation Plan. Door #4 was locked, exit sign removed, plywood placed over the door front and signage was posted directing emergency evacuation traffic to door #7 in the main dining room.

A staff member was assigned 24/7 to door #2 and #3 from 5:00pm August 10, 2011 through 3:00pm August 17, 2011 to ensure no resident was able to exit these doors unsupervised until the areas of construction outside those doors were secured. On August 17, 2011, the final fencing was installed that ensured all areas of construction were secure from all exit doors (#2, #3, #4, #7, #8, and #9).

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F 323 Continued From page 2
one of the exits. There was no evidence the facility had revised the evacuation plan to address changes during the construction.

Review of the Fire, Evacuation and Disaster Plan Summary and interview with the Maintenance Director, on 08/10/11 at 2:45 PM, revealed staff was to evacuate residents through pre-assigned exits. Further review and interview revealed sixty-two (62) of the facility's one hundred nine (109) residents would be evacuated through the nearest exits, which were Exits #2, #3 and #4. Forty-seven (47) of the facility's residents would be evacuated through Exits #8 and #9. Exit #7 was located off the dining room and the number of residents evacuated through this exit would vary if the dining room was in use at the time of the evacuation.

Observation during a walking tour, on 08/10/11 at 1:47 PM, revealed Exit #2 allowed access to a grassy hill to the left, a pile of dirt directly in front and a rough uneven embankment to the right. Further observation revealed there was no egress or sidewalk outside this exit. Additional observation revealed the orange safety fencing/netting was laying on the ground and there was no restriction or barrier to block off the construction area.

Observation, on 08/10/11 at 1:58 PM, of the area outside Exit #3, revealed a sidewalk next to an area of the embankment which had been dug out creating a forty (40) inch drop to the concrete curb below. Observation revealed the orange netting outside Exit #3 collapsed under the weight of the surveyor's hand. The Maintenance Director stated the orange netting/fence would

F 323 In-servicing began for all staff on August 10, 2011 on this update to the emergency evacuation plan. In servicing began with all staff assigned to duty this date and continued through August 12, 2011 to ensure no staff received assignment until completion of the in-service. This in-service was presented by the Director of Nursing and Assistant Director of Nursing and continued through August 12, 2011 at which time the 2nd update to the Emergency Evacuation Plan was completed and in servicing of all staff regarding the new update began.

A 2nd update to facilities Emergency Evacuation Plan was completed on August 12, 2011. This Emergency Evacuation Plan addressed the emergency exit route to be used for Door #2, #3, and #4. On August 12, 2011, the sidewalk was reinstalled leading to the newly paved parking lot allowing doors #2, #3, and #4 to evacuate to a paved way. Door #4 was placed back in use this same date and a 3rd staff member was placed at this door to monitor 24/7 along with door #2 and #3 until August 17, 2011 when the areas of construction were secured. In-servicing for this 2nd update began on August 12, 2011 and was completed on August 17, 2011. During the in-servicing process, no staff was allowed to take assignment until they received the training and the in-service record was signed. This Addendum now accompanies the facilities Emergency Disaster Plan that continues to be presented in each new employee orientation and annually.

Signage was posted on doors #2, #3 and #4 on August 19, 2011 and remains posted with arrows and instructions for staff and visitors to identify the evacuation route.

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F 323	<p>Continued From page 3</p> <p>not support a resident's weight if she/he fell. There was four (4) foot orange safety netting/fence which ran from the corner of the building to just past Exit #3. Observations revealed the construction area was accessible from both ends of the safety netting/fence. There was rough uneven piles of limestone gravel, broken hard plastic pipe with sharp edges and a stack of concrete slabs observed in the construction area.</p> <p>Observation, on 08/10/11 at 2:10 PM, revealed Exit #4 exited onto a concrete porch/pad which led to a four (4) and one (1) half inch drop onto an area covered with limestone gravel. Additionally, observation revealed there was a thirty-eight (38) inch opening, as measured by the Maintenance Director, to the left of the concrete porch/pad where residents, staff, or visitors could access the construction area.</p> <p>Observations, on 08/10/11 at 2:45 PM, revealed Exits #7, #8 and #9 exited onto the facility's parking lot. Observation revealed there were no barriers in place to prevent access to the construction site. Additionally, the facility failed to restrict access to a walkway between the end of the building and dumpsters allowing access to the construction area near Exits #2, #3 and #4.</p> <p>Interview, on 08/10/11 at 2:25 PM, with the Construction Manager revealed the facility had not reviewed regulatory requirements which could effect the construction process, as it related to maintaining a safe environment should residents get out of the building. He stated he thought the construction for parking lot began on 08/12/11, however the "Daily Log" revealed the construction</p>	F 323	<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 first met on Friday August 26, 2011. This team will meet weekly for 4 weeks and monthly thereafter. The Life Safety team set-up a drill calendar for the next 12 months to include, fire drills, evacuation drills, elopement drills and tornado drills and will continue on an annual schedule.</p> <p>The Life Safety team has implemented safety rounds to monitor for potential hazards in the facility and submit concerns through the facilities Continuous Quality Improvement program for review and recommendations as needed. These rounds will be completed weekly x 3 weeks, then monthly.</p> <p>An in-service was given to all staff on the facilities Fire and Disaster Programs. This in-service was presented by the Assistant Director of Nursing and Weekend House Supervisor from August 27 through September 7, 2011. The Emergency Disaster Plan including Fire, Evacuation, Tornado and Elopement Plans will be presented in each new employee orientation and annually.</p> <p>An in-service was provided for all staff on the facilities Elopement Prevention and Management policy. This policy includes how to respond to an alarm activation stressing the importance of "immediate action". A written test was given to all staff following the in-service to ensure comprehension. The Elopement Prevention and Management in-service and competency testing was presented by the Director of Nursing and Assistant Director of Nursing and was completed</p>	

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F 323 Continued From page 4 began on 05/26/11.

Interview, on 08/10/11 at 2:47 PM, with the Maintenance Director revealed the facility failed to monitor construction changes which would effect resident safety in the event of an evacuation.

Interview, on 08/10/11 at 3:00 PM, with the Owner Representative of Construction revealed he was responsible for informing the facility of changes which occurred during the construction. He stated he was not familiar with the long term care regulations related to the need to keep residents safe.

Interviews, on 08/10/11 between 3:41 PM and 4:33 PM, with Licensed Practical Nurse (LPN) #1, Registered Nurse (RN) #2, Kentucky Medication Aide (KMA) #5, and State Registered Nurse Aides (SRNAs) #1, #2, #3, #4, #5 and #7 revealed they were not aware of the need to alter evacuation procedures due to the construction. These staff members stated they would use the closest exit to evacuate residents. They indicated Exits #2, #3 and #4 would be the primary means of evacuation for residents under their care.

Interview, on 08/10/11 at 4:50 PM, with the Director of Nursing (DON) revealed the facility was aware they would need to make changes to the evacuation routes during the construction. Further interview revealed she had not been made aware of any changes to evacuation routes and had not educated the staff on changes to the evacuation plan due to the construction.

Interview, on 08/11/11 at 1:30 PM via telephone, with the Interim Administrator revealed the facility

F 323 on August 15, 2011. During the next 2 weeks, a 5% random selection of staff repeated the test to ensure comprehension. This was presented by the Assistant Director of Nursing and was completed September 2, 2011.

An in-service was also provided for all staff on Accidents and Supervision. This in-service included definitions, an overview of resident safety in the facility including supervision and identifying risk factors for each resident. It also emphasized the importance of evaluating and analyzing hazards and risks, implementing interventions, providing adequate supervision, providing assistive devices, monitoring effectiveness, modifying interventions, and following each residents comprehensive care plan. This in-service was completed by the Director of Nursing, Assistant Director of Nursing and Weekend House Supervisor on August 25, 2011. It has also been added to new employee orientation that is presented by the Assistant Director of Nursing.

In addition, Staff Nurses are completing audits of all care planned assistive devices to ensure the care plans are being followed. These audits will be completed every shift, every day x 2 weeks beginning September 1, 2011, then every shift 3 days a week x 4 weeks. These audits are reviewed by the Unit Managers each morning according to schedule. Any trends in non-compliance are brought to the weekday Continuous Quality Improvement Meeting for their review and recommendations.

All staff are receiving re-inservicing on the facilities abuse policy and all nursing staff are receiving re-inservicing on Accidents and supervision and the importance of always

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Continued From page 5
had discussed changes that would need to take place during the construction. She stated the facility had not discussed changes to the evacuation plans. Additionally, she stated she was not aware the facility had lost the means of egress from Exits #2, #3 and #4.

The facility identified twenty-six (26) residents to be at risk of wandering/elopement from the facility. Review of the clinical records revealed the facility assessed Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25 and #26 at risk for wandering/elopement from the facility.

Interview with the Maintenance Director, on 08/10/11 at 2:50 PM, revealed the only exit doors equipped with the Wanderguard System were Exits #1 and #6

Observation, on 08/10/11 at 11:00 AM, revealed a nurse directed a confused resident away from Exit #3, and said "you cant go out that door".

Observations during the walking tour and interview with the Maintenance Director, on 08/10/11 at 2:48 PM, revealed Exits #2, #3, #4, #7, #8 and #9 were equipped with panic bars which allowed someone to exit after fifteen (15) seconds of continuous pressure.

In additional interview, on 08/11/11 at 2:45 PM, the DON stated the facility held a Quality Assurance meeting on 08/21/11. She stated during that meeting the Medical Director made the facility aware they would need to address issues related to emergency exits during the

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following the care plan with focus on the appropriate transfer of residents. A test is being given on following the residents care plans to ensure comprehension. These in-services began September 13, 2011 and will be completed by September 19, 2011 and are being presented by the Assistant Director of Nursing, Unit Managers, Weekend House Supervisor and Restorative Nurse.

Monitoring

The Housing Director is responsible to oversee the construction project on a daily basis. As construction continues, the construction manager will alert the Housing Director of any changes that will affect the evacuation and/or safety of the residents and will immediately report any unscheduled changes as they may occur. In the absence of the Housing Director, the order for these alerts will be 1) Nursing Home Administrator, 2) Director of Nursing, and 3) Lead Maintenance Technician. The construction manager will meet each week with the Housing Director to inform him of construction activity for the upcoming week. The Housing Director will report any planned changes to the Nursing Home Administrator. Any changes that will affect residents and staff will be reviewed at the morning, weekday Continuous Quality Improvement Meeting. Any in-servicing needed for staff will be reviewed and documented and will begin as directed by the Administrator and/or Director of Nursing.

The Nursing Home Administrator and Director of Nursing will make documented rounds Monday through Friday to assess for any possible breach of safety or concerns of safe evacuation of residents. These rounds will also include appropriate function of the facilities security

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F 323	Continued From page 6 construction. The DON stated the medical director informed the facility they would need to remove signs and place barriers when exits were not in use. He also informed the facility of the need to place signs to direct people to the appropriate exit.	F 323	system. The Lead Maintenance Technician will make the same intended rounds Monday through Friday 2x/day. These 4 rounds will extend throughout the day beginning from approximately 7:00am-8:00am and 4:00pm- 5:00pm. These rounds are an addition to the Cont. on pg 7.1 of 16	
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of facility's policy, and review of the evacuation route it was determined the facility failed to be administered in a manner which enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical well-being of each resident, related to maintaining an environment as free of hazards as possible and that residents received adequate supervision to prevent accidents. On 05/26/11, the facility's construction project effected the safety of the facility's one hundred nine (109) residents, one hundred forty-one (141) employees, and visitors. On 05/26/11, grading of facility grounds created environmental hazards to residents. The facility's administration failed to ensure adequate safety devices were put into place to restrict/prevent resident access to the construction areas. Additionally, the facility's Administration failed to	F 490	<u>F490</u> <u>Effective Administration / Resident</u> <u>Well-being</u> Targeted Residents No residents were targeted under this practice but the facility realizes that all residents had a potential to be affected. The facility held an emergency Mini-QA Meeting on 8-11-11 to review all issues surrounding exits, accidents and supervision and resident safety regarding construction and facility staffs training on Emergency Disaster preparedness. On 8-10-11, 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 door #4 evacuation to door #7. All staff was trained by the Director of Nursing, the 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	

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09/19/2011

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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every shift continuous rounds made by the Charge Nurse that ensure appropriate function of the facilities security system. The Weekend House Supervisor will also complete 2x/day documented rounds ensuring the appropriate function of the facilities security system. These rounds began August 15, 2011.

The Housing Director will be made aware of any planned weekend construction activity during his weekly meetings with the Construction Manager. In the event of scheduled weekend construction activity, the Housing Director will notify the Nursing Home Administrator/ Director of Nursing who will make the Weekend House Supervisor aware for inclusion of monitoring for any possible breach of safety or concerns of safe evacuation of residents. The Weekend House Supervisor will immediately report any identified concern to the Nursing Home Administrator or the Director of Nursing who will take necessary action to remedy immediately.

From these documented rounds, any construction activity that could affect the health and safety of residents or concern with the facilities security system will be reviewed and remedied immediately. A report of all rounds will be brought to the daily, Monday through Friday Continuous Quality Improvement Meeting for review and recommendations as needed.

All reports of construction activity and documented rounds completed by the Nursing Home Administrator, Director of Nursing, Lead Maintenance Technician, Charge Nurses and Weekend House Supervisor will be brought to the monthly Quality Assessment and Assurance Meeting to ensure that measures are consistently implemented as indicated by construction activity

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			<p>and consistent appropriate function of the facilities security system.</p> <p>In the event of any breach of safety or concern with the safe evacuation of residents, the current plan will be evaluated with revisions and increased monitoring as needed.</p> <p>Concerns identified by the weekly environmental Life Safety team rounds and through the Nursing assistive device audits that were submitted to the Continuous Quality Improvement Meeting will also be submitted to the monthly Quality Assessment and Assurance committee for their review, evaluation and recommendations including increased monitoring as needed.</p> <p>The Quality Assessment and Assurance Meeting will meet weekly x 6 weeks beginning August 11, 2011 and then monthly x 3 months.</p>	09/20/11

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STATEMENT OF DEFICIENCIES
PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

185248

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

C

08/19/2011

NAME OF PROVIDER OR SUPPLIER

AYRE 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)

(X5)
COMPLETION
DATE

F 490

Continued From page 7

review the evacuation plan and educate staff related to the need to seek alternative methods of exit for residents while the construction was being completed.

The findings include:

Review of the facility's Fire, Evacuation and Disaster Plan Summary, no date, revealed staff was to inspect the primary exit and determine if it was usable. If the primary exit was not usable then the secondary exit was to be used. If both exits were blocked staff was to attempt to clear one (1) of the two (2) exits.

Review of the construction company's "Daily Log" revealed grading and excavation for the construction of a new building began on 05/26/11.

A walking tour and interview with Interim Maintenance Director, on 08/10/11 at 1:47 PM, revealed the facility was not aware the egress had been removed by the construction company. Additionally, the Maintenance Director revealed the facility was aware of the need to make changes to evacuation plans and exit designation when the construction affected an exit. Review of the facility's emergency exit plan and interview with the Interim Maintenance Director, on 08/10/11 at 2:00 PM, revealed Exits #2, #3, #4, #7, #8 and #9 were equipped with panic bars and there was no "Wanderguard" alarm system on these doors. Observation, on 08/10/11 at 1:47 PM, revealed construction debris and rough uneven surfaces which represented a serious risk to residents. (Refer to F-323).

Interviews with nine (9) staff members, on

F 490

the floor in orientation. 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. On August 16, 2011 the area by Greenfield Drive leading to the future basement area was secured by chain link fencing, by August 17, 2011 chain link fencing was installed around the new parking lot area. On August 15, 2011 a permanent Administrator was hired and was updated on all related issues, plans, etc. On August 17, 2011 the Administrator directed that a sign be posted in each Department with the Department's specific responsibilities in the event there was a fire. Per the Administrator's directive all staff has been in-serviced on QA along with all other tags related to construction, resident supervision/safety and disaster preparedness. On 8-19-11 the QAA committee met with new Administrator and decided to meet weekly thereafter for the next 4 weeks and then to meet monthly for the next three months to monitor for any systemic issues. On 8-19-11 the QAA committee approved a new CQI form presented by the Administrator that was placed by the time clock in the employee break area so all employees could have access to it. The form is pink and all employees were in-serviced on this form and what QAA committee was and what the policy on QAA is between 8/20/11 and 8/25/11. The new pink CQI form can be filled out by all employees when they see a deficient practice or an area of improvement. If the Interdisciplinary Team feels this is a concern an Action Team will be put into place and an Investigative form will be filled out to identify the root cause and need for an action plan. All CQI forms will be brought to QAA for monitoring.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186248	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/18/2011
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NAME OF PROVIDER OR SUPPLIER SAYRE CHRISTIAN VILLAGE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3848 CAMELOT DRIVE LEXINGTON, KY 40517.
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F 490 Continued From page 8
 08/10/11 between 3:41 PM and 4:33 PM, revealed they would use the closest exit in the event of an evacuation. They identified Exits #2, #3, and #4 as means to evacuate. Interview further revealed the facility's administration had not provided training related to the need to change the evacuation plans/routes during the construction.

Interview, on 08/11/11 at 1:30 PM, with the Interim Administrator revealed she had no knowledge the construction company had removed the egress for the three (3) exits. In additional interview, the Interim Administrator stated the facility had discussed the changes that would be occurring during the construction, but did not discuss the need to make changes to the evacuation plans or education for staff related to safely evacuating residents.

Interview, on 08/11/11 at 2:45 PM, with the Director of Nursing revealed during the June 21, 2011 Quality Assurance Committee Meeting the Medical Director notified the facility of the need to address safety issues related to the construction outside the building. The issues discussed included the need to make changes to the evacuation plans and routes and to provide staff with education related to these changes. Additionally, per the DON the Medical Director discussed the need for securing the construction area to prevent access by residents on 07/18/11. (Refer to F-520)

During an interview, on 08/19/11 at 11:30 AM, the Medical Director stated he had experienced issues related to construction at another facility. He explained as part of that experience he was

F 490 Identification of Other Residents
 All 109 residents had the potential to be affected by this practice.

Systemic Changes
 A permanent Administrator started on August 15, 2011 and was updated on all issues, concerns regarding complaint survey the prior week. The Administrator directed that the Housing Director meet with the Construction Manager on a weekly basis and then the Housing Director will meet with the Administrator on a weekly basis regarding construction plans for the upcoming week. The Administrator directed that the QAA team meet an additional 5 weeks in a row to ensure facility was discussing all related issues communicating changes with the Medical Director, plans regarding resident safety, exits, accident/supervision, the QA process for facility, Emergency and Disaster Preparedness and any updates on construction that could potentially effect safety of facility residents staff and visitors. The Administrator directed on August 15, 2011 that the Director of Nursing, Lead Maintenance Technician and Administrator perform daily M-F rounds to ensure egress is in compliance. The charge nurse would also continue checking the facilities security system every shift, 7 days a week to ensure all doors are functioning properly. On August 17, 2011 all construction area was fenced in by chain link fencing to ensure it is secure. The Administrator initiated a Life Safety Code Committee that met on August 26, 2011 to discuss all issues brought up in survey process. The Life Safety Code committee will continue to meet weekly for the next 4 weeks then monthly thereafter. The Life Safety Code Team will perform monthly life safety rounds, perform Disaster Drills and ensure all staff are familiar

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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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F 490	Continued From page 9 aware this facility would need to make changes to its system during the time the construction was underway. The Medical Director stated he informed the facility they would need to make changes to include evacuation plans, training of staff, and insuring residents were safe when outside the building. There was no documented evidence the facility's administration had evaluated and/or revised the evacuation plan related to the facility exits which led to a construction area with potential hazards. The facility's Administration failed to monitor construction progress in order to make the necessary revisions to the evacuation plan or to install safety devices to restrict resident access to the construction areas, as environmental hazards were created. Furthermore, the facility's Administrator failed to act on information provided by the Medical Director related to the facility's need to develop a system to monitor the construction and respond in a manner that would insure resident safety.	F 490	with facility Fire and Disaster Plan. The Administrator has verified that all in-servicing regarding accidents and supervision, Fire and Disaster/Emergency Preparedness, current evacuation route, QA process have been given to all employees and will be given to all new employees upon hire. Monitoring All systemic issues will be brought to QAA for monitoring and effectiveness. Random tests will be given out beginning the week of September 5, 2011 to 5 random employees for 3 months to test their on-going knowledge of the QA program and the facility Fire and Disaster Preparedness. These results will be brought to the QA committee for monitoring of effectiveness of compliance in F490 for 3 months.	09/20/11
F 518 SS-E	483.78(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observations, interview, review of the facility's Fire, Evacuation and Disaster Plan Summary, and daily construction logs it was	F 518	<u>F518</u> <u>Train all Staff on Emergency Procedures/ Drills</u> 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	

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F 518	<p>Continued From page 10</p> <p>determined the facility failed to update their emergency evacuation plan related to ongoing construction and failed to train all staff in emergency procedures related to safety and evacuations. On 05/28/11, grading and excavation began outside the building in preparation for an expansion of the facility. On 08/08/11, as part of the construction project the egress for fire Exits #2, #3 and #4 was removed. The facility failed to have an effective system in place to monitor the construction progress and make changes to the evacuation plan and provide staff with education related to those plans.</p> <p>The findings include:</p> <p>Review of the facility's Fire, Evacuation and Disaster Plan Summary, not dated, revealed staff were to locate and evacuate residents through a safe exit.</p> <p>Observation, on 08/10/11 at 1:00 PM, revealed the egress for exit #4 had been removed as part of the facility's construction project. During a walking tour and interview, on 08/10/11 at 1:47 PM, with the Interim Maintenance Director it was revealed the section of the sidewalk which had been removed for construction also prevented egress to a public way for Exits #2 and #3, as well as #4. The Maintenance Director was not aware the sidewalk had been removed and after consulting with the construction supervisor stated the sidewalk had been removed on 08/08/11. The Maintenance Director stated that due to the lack of knowledge that the egress had been removed he had not revised the evacuation plan and staff had not been educated related to the change in exits.</p>	F 518	<p>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. All staff were trained by the Director of Nursing, the 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, #4 at 3:00 p.m. On August 17, 2011 a sign was posted in each Department with that Department's specific responsibilities in the event there was a fire.</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 as of 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-P and will notify staff on these changes when</p>	

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F 518 Continued From page 11

Interviews, on 08/10/11 between 3:41 PM and 4:33 PM, with Licensed Practical Nurse (LPN) #1, Registered Nurse (RN) #2, Kentucky Medication Aide (KMA) #5, and State Registered Nurse Aides (SRNAs) #1, #2, #3, #4, #6 and #7 revealed they would use the closest exit to evacuate residents. They stated they had not been informed to alter evacuation procedures due to the constructions. These staff members stated Exits #2, #3, and #4 would be the primary means of evacuation for residents under their care.

Interview, on 08/11/11 at 1:30 PM, with the Interim Administrator revealed she could not explain how the facility failed to recognize the missing egress and make the necessary changes to the evacuation plan. She stated the facility had discussed the need to make changes during the construction, but those changes did not include the need to change evacuation plans and educate staff on the revised evacuation plan.

Interview with the Director of Nursing (DON), on 08/11/11 at 2:45 PM, revealed during the 08/21/11 Quality Assurance Meeting, the facility's Medical Director informed the facility they would need to revise evacuation plans and educate staff on the revisions, as the construction progressed. The DON was unable to explain how the facility failed to identify the missing egress and make the necessary changes to keep residents safe.

F 520 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS

A facility must maintain a quality assessment and

F 518 needed. The charge nurse will also be checking each exit door every shift beginning August 15, 2011 Sunday-Saturday to ensure the facilities security system is functioning properly. Any issues found will be brought to the Administrator's and or Director of Nursing's attention immediately and will also be discussed in the daily M-F Continuous Quality Improvement Meeting effective August 15, 2011 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 the 2nd to address on 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, Dietary and in Laundry 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
Cont. on pg 12.1 of 15

F 520 F520
QAA Committee Members / Meet Quarterly / Plans

Targeted Residents
No residents were targeted under this practice

PRINTED: 09/02/2011
FORM APPROVED
OMB NO. 0938-0391

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

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08/19/2011

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2840 CAMELOT DRIVE

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			<p>monthly meetings. The Life Safety Committee will also hold an emergency meeting in the future if any changes to the evacuation/ and or emergency procedures need to be updated and will be responsible for updating fire and disaster books, placing signs on exits doors when applicable and training staff on temporary emergency procedures. 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 was 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 alarm using the nearest manual fire alarm box and then shall execute immediately their duties as outlined in the fire safety plan. The Life Safety Code Committee will begin doing random tests to 5 random staff members per month for three months beginning the week of September 5, 2011 to test staff member's knowledge of the facility's Disaster Plan.</p> <p>The facility conducted unannounced fire drills by Life Safety Committee members to further educate staff on fire/disaster/elopement procedures. Unannounced 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. Unannounced tornado drills were conducted at 8-29-11 at 3:45 p.m., 8-30-11 at 2:29 p.m., 8-30-11</p>	

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			<p>at 2:10 p.m. Unannounced elopement drills were conducted on 8/27/11 at 2:50 p.m., 8/29/11 at 1:55 p.m. and 8/31/11 at 4:08 p.m. by Social Services. All new staff will be in-serviced on Fire Disaster Emergency preparedness in orientation.</p> <p>Monitoring The Life Safety Code Team will bring any concerns found during drills to the Life Safety Code Team to monitor for educational needs, etc.</p> <p>Any concerns found during drills along with tests given to staff, any issues/concerns found through the rounds completed daily M-F by the Administrator, Lead Maintenance Technician, Director of Nursing, the daily, every shift rounds by the charge nurse and weekly Life Safety Team rounds (weekly for three weeks then monthly) will be brought to the facilities Quality Assurance Committee Meetings which will be meeting monthly x 3 months to ensure there are no issues with staff education in facility's Fire and Disaster Preparedness and that facility is in compliance with F518 and that plan is place is effective.</p>	09/20/11

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F 520	<p>Continued From page 12</p> <p>assurance committee consisting of the director of nursing services; a physician designated by the facility, and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary, and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Fire, Evacuation and Disaster Plan, it was determined the facility failed to ensure the Quality Assessment and Assurance Committee (QA) was effective in the identification and correction of quality issues with the potential to effect resident safety. The facility's QA failed to ensure the residents' environment remained as free of accident hazards as is possible; and each resident received adequate supervision to prevent accidents. The facility failed to have a system in place to monitor changes in construction which could effect resident safety.</p>	F 520	<p>but the facility realizes that all residents had a potential to be affected. The facility held an emergency Mini-QA Meeting on 8-11-11 to review all issues surrounding exits, accidents and supervision and resident safety regarding construction and facility staff's training on Emergency Disaster preparedness. 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 door #4 evacuation to door #7. All staff were trained by the Director of Nursing, the 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, #4 to a paved way at 3:00 p.m. On August 16, 2011 the area by Greenfield Drive leading to the future basement area was secured by chain link fencing, and by August 17, 2011 chain link fencing was installed around the new parking lot area. On August 17, 2011 a sign was posted in each Department with the Department's specific responsibilities in the event there was a fire.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 520	<p>Continued From page 13</p> <p>On 08/21/11, during a QA meeting the facility's Medical Director informed the facility of the need to monitor emergency exits, make necessary changes, and educate staff on those changes. Additionally, during the 07/15/11 QA meeting, the Medical Director informed the facility of the need to have barriers in place during construction. On 08/08/11, the construction company removed a section of sidewalk which provided egress to a public way for three (3) of eight (8) emergency exits (exits #2, #3, and #4). Interview with nine (9) staff on 08/10/11 revealed they had no knowledge of the need to alter emergency evacuation procedures.</p> <p>The findings include:</p> <p>Review of the facility's Fire, Evacuation and Disaster Plan, not dated, revealed staff was to identify and evacuate residents through the appropriate exits. There was evidence the plan had been revised to address the lack of egress from Exits #2, #3 and #4 on 08/10/11.</p> <p>Observation, on 08/10/11 at 1:00 PM, revealed the egress for Exit #4 had been removed.</p> <p>Observation during a walking tour and interview with the Interim Maintenance Director, on 08/10/11 at 1:47 PM, revealed the removal of the sidewalk at exit #4 also effected the egress from exit #2 and #3. He stated he was not made aware the egress had been removed.</p> <p>Interviews, on 08/10/11 between 3:41 PM and 4:33 PM, with nine (9) staff revealed they had not been informed to modify the evacuation of residents through Exits #2, #3 and #4. The nine</p>	F 520	<p>All staff have been in-serviced on QA along with all other tags related to construction, resident supervision / safety and disaster preparedness. On 8-19-11 the QAA committee met again and decided to meet weekly thereafter for the next 4 weeks and then will meet monthly for the next three months to monitor for any systemic issues. On 8-19-11 the QAA committee approved a new CQI form that was placed by the time clock in the employee break area so all employees could have excess to it. The form is pink and all employees were in-serviced on this form and what QAA committee was and what the policy on QAA is between 8/20/11 and 8/25/11. The new pink CQI form can be filled out by all employees when they see a deficient practice or an area of improvement. If the Interdisciplinary Team feels this is a concern an Action Team will be put into place and an Investigative form will be filled out to identify the root cause and need for an action plan. All CQI forms will be brought to QAA for monitoring.</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 updates regarding construction plans for the upcoming week. The Director of Housing began meeting weekly with the Administrator to update on any construction plans for the upcoming week. In absence of the Director of Housing the Administrator will meet weekly with the Construction Manager. The</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195248	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/19/2011
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NAME OF PROVIDER OR SUPPLIER SAYRE CHRISTIAN VILLAGE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 8848 CAMELOT DRIVE LEXINGTON, KY 40517
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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
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(9) staff stated they would evacuate residents through the nearest exit and indicated they would use Exits #2, #3 and #4.

Interview, on 08/11/11 at 1:30 PM via telephone, with the Interim Administrator revealed she was not aware the QA had discussed issues related to making changes to the evacuation plans during the course of construction. She was unable to explain why no action had been taken to address the change in egress for three (3) of eight (8) exits.

Interview, on 08/11/11 at 2:45 PM, with the Director of Nursing revealed the QA Committee met on 08/21/11 and the Medical Director informed the facility they would need to modify the evacuation routes as necessary during the construction. She further stated he had informed the facility they would need to change signs and train staff with each of the changes. The Director of Nursing was unable to explain why the facility's QA had failed to address the removal of the egress outside Exit #4. She further stated the Medical Director had informed the facility they would need to have barriers in place during the July 15th QA meeting. She stated she did not work on 08/08/11 and 08/09/11 and was not made aware the egress had been removed. She was unable to explain why no action had been taken through the facility's QA Committee to address the change in egress for Exits #2, #3 and #4.

Interview, on 08/18/11 at 11:30 AM, with the Medical Director revealed he had made the facility aware of the need to address closure of the fire exit, alter evacuation plans, and educate staff on how to exit the facility in the event of

F 520

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

The Quality Assurance Team has been meeting weekly on 8-11-11, 8-19-11, 8-23-11, 8-30-11, 9-6-11 and will continue to meet weekly for one more week, a total of 6 weeks then will meet one time per month for 3 months to help monitor any systemic issues found in this complaint survey and others identified within facility by facility staff. The staff were in-serviced on the QAA committee policy along with the Continuous Quality Improvement form and policy from 08/20/11 through 08/25/11. The staff also was given a written test to prove their knowledge on the QA process during these in-services. The CQI pink form was implemented on 8-19-11 to help make all employees aware of the importance and the need to identify any systemic issues within the facility. All of these issues will be brought to QAA for review and monitoring. The QAA agenda was updated on 8-19-11 to include the CQI form monitoring. A CQI form was filled out identifying each deficiency noted in this survey for monitoring of each written plan of action.

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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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F 520	Continued From page 15 emergency as needed while the construction was occurring.	F 520	Monitoring All systemic issues will be brought to QAA for monitoring and effectiveness. Random tests will be given out beginning the week of September 5, 2011 to 5 random employees for 3 months to test their on-going knowledge of the QA program. These results will be brought to the QA committee for 3 months for monitoring of effectiveness of compliance in F520.	09/20/11