

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

PRINTED: 09/19/2012
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 04/03/2012
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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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(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	F 000		
F 281	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure Physician's Orders were followed for one (1) of three (3) sampled residents (Resident #2). Resident #2 was administered insulin on 02/01-02/03/12; however, the insulin had been discontinued 10/05/12.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #2 on 06/22/11 with diagnoses which included Diabetes Mellitus (DM).</p> <p>Review of the Physician's Orders revealed an order, dated 10/05/11, to discontinue nutritional insulin at meal time (Novolog 100 units/milliliter (ml) eight (8) units Subcutaneous every morning and ten (10) units at lunch and supertime).</p> <p>Review of the February 2012 Medication Administration Records (MARs) revealed the facility administered Resident #2 Novolog 8 units every morning on 02/01/12, 02/02/12 and</p>	F 281		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 281	<p>Continued From page 1 02/03/12.</p> <p>Review of the 02/04/12 Incident Report revealed the medication error was discovered on 02/04/12.</p> <p>Interview, on 04/03/12 at 10:00 AM, with Licensed Practical Nurse (LPN) #1 Unit 2 Coordinator revealed on 10/05/11 the Physician gave a verbal order to discontinue the resident's insulin that was ordered to be given in the AM, at lunch and supertime. However, the order to give the medication reappeared on the February 2012 Recapitulated Physician's Orders and MARs. Continued interview with LPN #1 revealed the nurse responsible for ensuring the Physician's Orders and MARs were correct failed to remove the discontinued order from the Physician's Orders and MARs. The same nurse also administered the insulin to the resident.</p> <p>Interview on 04/03/12 at 11:42 AM with LPN #2 revealed she did not remember an issue with insulin, and no one had told her she made an error. She stated she attended an inservice in February regarding proper procedure for transcription of medication orders because errors were made.</p> <p>Interview, on 04/03/12 at 9:40 AM, with the Director of Nursing (DON) revealed LPN #2 compared chart orders with the February 2012 Physician's Orders and had failed to catch the error on the February 2012 Physician's Orders. LPN #2 also administered the medication to the resident.</p>	F 281			