

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

PRINTED: 11/30/2010
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 11/10/2010
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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>F 000</p> <p>F 282 SS=D</p>	<p>INITIAL COMMENTS</p> <p>A Recertification Survey, and an Abbreviated Survey was conducted on 11/08/10 - 11/10/10. A Life Safety Code Survey was conducted on 11/09/10. Deficiencies were cited with the highest Scope and Severity of an "F". ARO #KY00015465, ARO #KY00015467 and ARO KY00015582 were unsubstantiated.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide care by qualified persons in accordance with each resident's Plan of Care for two (2) of twenty six (26) residents (Resident #3 and Resident #11). Resident #3 was to have an abduction pillow between his/her legs when in the bed and heel boots on when out of bed. Observations on 11/08/10 and 11/09/10 revealed the abduction pillow was not in use when the resident was in the bed. Observations on 11/09/10 and 11/10/10 revealed the heel boots were not on when the resident was out of the bed. Resident #11 was to have an abduction pillow at all times except when Activities of Daily Living (ADLs) were being performed. Observations during the course of the Survey revealed the abduction pillow was not in use for Resident #11.</p> <p>The findings include:</p>	<p>F 000</p> <p>F 282</p>	<p style="text-align: center;">RECEIVED JAN - 7 2011 BY: _____</p> <p>F 282</p> <p>Immediate Corrective Action For Residents Found To Be Affected</p> <ul style="list-style-type: none"> Resident #3's abduction wedge pillow and heel boots were put into place on November 10, 2010 as care planned and staff were re-educated, by the DON and Weekend Nurse Supervisor beginning November 10, 2010 through November 14, 2010, on this resident's need for the use of the abduction wedge pillow when in bed and need for use of heel boots when out of bed. Resident was assessed to ensure no negative outcome relative to this deficient practice. Resident #11's abduction wedge pillow was put into place on November 10, 2010 as care planned and staff were re-educated, by the DON and Weekend Nurse Supervisor beginning November 10, 2010 through November 14, 2010, on this resident's need for the use of the abduction wedge pillow at all times except when ADL care is being provided. (NOTE: There was no order or care plan intervention for heel boots for this resident at the time of survey). Resident 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jimmy R. SCL</i>	TITLE: <i>ADMINISTRATOR</i> AMENDED (X6) DATE: <i>01/06/11</i>
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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 282	<p>Continued From page 1</p> <p>1. Record review revealed Resident #11 was admitted to the facility on 04/18/09 with diagnoses which included Osteoporosis, Alzheimer's, Rheumatoid Arthritis and Status Post Left Hip Fracture.</p> <p>Observation of Resident #11 on 11/08/10 at 9:40 AM, 10:30 AM, 11:15 AM, 12:15 PM, and 12:50 PM revealed there was not an abduction pillow or heel boots in use. Observation on 11/09/10 at 8:12 AM, 9:30 AM and 10:45 AM revealed there was not an abduction pillow or heel boots in use when Resident #11 was in bed or up in the Geri Chair.</p> <p>Review of the Physicians Orders for October 2010 and November 2010 revealed an order for the abduction pillow to be used at all times except when personal care was being performed to decrease the risk for skin breakdown and as a fractured hip precaution.</p> <p>Review of the Interdisciplinary Plan of Care dated 06/11/10, revealed an intervention for the abduction pillow at all times except when ADLs were performed to decrease skin breakdown and for fractured hip precautions. Further review of the Resident Daily Care Plan dated November 2010, revealed the abduction pillow was an intervention on that Care Plan.</p> <p>Interview with CNA #6 on 11/10/10 at 5:15 PM, revealed she looks at the Nurse Aide Care Plan and gets report from the Charge Nurse. CNA #6 further stated she will look at the CNA Care Plan Book at the Nurse's Station if goes to another unit to work to familiarize self with the residents.</p>	F 282	<p>was assessed to ensure no negative outcome relative to this deficient practice.</p> <p>Identification of Other Residents With The Potential to be Affected</p> <ul style="list-style-type: none"> ◆ An audit of all residents was completed on December 8, 2010 by the DON and designated licensed staff members reviewing care planned interventions to ensure 100% compliance. This audit included ensuring that all positioning devices were in place as indicated. ◆ Inservice is being provided by the DON/licensed designee from December 9-11, 2010 for the nursing staff regarding the importance of following care planned interventions at all times including ensuring specific positioning devices are in place as indicated. <p>Measures Taken To Assure There Will Not Be a Recurrence</p> <ul style="list-style-type: none"> ◆ DON/licensed designee will inservice on December 9-11 of the responsibility of the licensed staff to monitor care that is being provided to the residents by the SRNA's under their supervision. ◆ Beginning December 13th, licensed staff will be responsible for completing rounds with documented findings each shift to ensure care planned interventions including positioning devices are in place. Any findings of non-compliance will be 	
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F 282	<p>Continued From page 2</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 11/10/10 at 3:15 PM revealed the CNAs sign the back of the Care Plan to indicate they were aware of the needs of the resident.</p> <p>Review of the signature space on the back of Resident #11 CNA care plan revealed that CNA #6 was Resident #11's usual care giver on the 3-11 shift.</p> <p>2. Record review revealed Resident #3 was admitted to the facility on 07/31/09 with diagnoses which included Hip Fracture, Mild Dementia, and Pressure Ulcer on the Coccyx.</p> <p>Observation of Resident #3 on 11/08/10 between the hours of 9:50 AM to 12:55 PM, and on 11/09/10 at 8:30 AM revealed there was not an abduction pillow in use when Resident #3 was in the bed. Continued observation of Resident #3 on 11/09/10 between the hours of 1:20 PM to 2:15 PM and on 11/10/10 at 11:45 AM to 1:15 PM revealed the resident had gripper socks on with no heel lift boots in use.</p> <p>Review of the Physician's Orders for November 2010 revealed the order for the abduction wedge when in bed and bilateral heel boots on while up in chair.</p> <p>Review of the Interdisciplinary Plan of Care dated 09/07/10, revealed an intervention for the abduction wedge while in bed, and bilateral heel boots when in the chair. Further review of the Resident Daily Care Plan dated November 2010 and the Certified Nurse Aide (CNA) Care Plan, revealed the abduction wedge and the bilateral heel boots were interventions on that Care Plan.</p>	F 282	<p>immediately corrected by the direction of the licensed nurse. The SRNA responsible for the non-compliance will receive re-education and/or disciplinary action by the DON or designated licensed staff member as deemed appropriate by facility Administration.</p> <ul style="list-style-type: none"> Beginning December 20th, the DON/licensed designee will complete weekly audits for 4 weeks on a 10% resident selection to ensure care planned interventions are being followed including care planned positioning devices. This audit will require direct observation of staff delivering care over all 3 shifts. <p>Monitoring Changes To Assure Continuing Compliance</p> <ul style="list-style-type: none"> DON/licensed designee audit results will be submitted to the Quality Assurance Committee for review and revision until the Quality Assurance committee has determined 100% compliance is achieved. Any area of non-compliance will require re-education by the DON/licensed designee, increased monitoring, and revision to the plan as deemed appropriate by the Quality Assurance committee to ensure 100% compliance. <p>Date of Completion:</p>	12-20-10

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F 282	Continued From page 3 Interview with CNA #7 on 11/09/10 at 3:15 PM, revealed she looked at the Nurse Aide Care Plan and got report from the Charge Nurse before she goes on the floor. CNA #7 further stated she did not notice the wedge or heel boots on the care plan, but these items were in the resident's room. Interview, on 11/09/10 at 3:05 PM, with the Director of Nursing revealed the CNAs sign the back of their Care Plan to indicate they were aware of the needs of the resident. Review of the signature space on the back of Resident #3's CNA care plan revealed CNA #7 was Resident #3's usual care giver on 7-8 shift.	F 282		
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to prepare and serve food under sanitary conditions. Observation, during the initial tour on 11/08/10, revealed the meat slicer was stored with particles of meat and grease on the blade and press. Observation of the evening meal tray line on 11/09/10 revealed the cook to change gloves several times without	F 371	F371 Immediate Corrective Action For Residents Found To Be Affected No specific resident(s) identified. However, no resident was identified in Infection Control Tracking and Trending report that would have been affected by this practice. <u>However, Dietary Manager immediately cleaned meat slicer on November 08; upon observation, Dietary Manager immediately inservice'd in-house staff on November 09 relative to proper hand washing, use of gloves and proper cleaning and storage of equipment.</u> Identification of Other Residents With The Potential to be Affected ♦ <u>Dietary Manager performed a sanitation inspection on November 09 to assure no additional issues were identified - none were noted.</u>	

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F 371	<p>Continued From page 4</p> <p>washing her hands between changes, and the assistant cook transferred the garlic toast from the pan to the tray line with her hands.</p> <p>The findings include:</p> <p>1. Observation during initial tour on 11/08/10 at 8:45 AM, revealed the meat slicer was stored with particles of meat and grease on the meat press and the blade.</p> <p>Interview with the Dietary Manager on 11/09/10 at 6:15 PM, revealed the meat slicer was stored dirty and she had cleaned it after the AM observation.</p> <p>2. Observation of the evening meal tray line on 11/09/10, at 4:55 PM to 5:55 PM, revealed the cook to change gloves without washing her hands between the glove changes at least four (4) times.</p> <p>During an interview with Cook #6 on 11/09/10 at 6:30 PM, she stated "I just wasn't thinking, my hands weren't dirty, I know to wash my hands anytime I remove gloves."</p> <p>3. Assistant Cook #8 was observed on 11/09/10 at 6:40 PM, to transfer garlic toast from the pan it was heated on to the tray line with her ungloved hand.</p> <p>Interview with Cook #8 on 11/09/10 at 6:35 PM, revealed she was in a rush and forgot to use the tongs. She stated she knew better.</p> <p>4. At 4:55 PM, during the tray line down time between units, Dietary Aide #7 was observed to be standing at the end of the tray line with her elbow resting in the plate covers.</p>	F 371	<p>♦ A review of the facilities Infection Control Program's tracking and trending report was <u>also</u> completed by the DON/licensed designee on December 10th to identify any resident which may have been affected. There were no residents identified.</p> <p>Measures Taken To Assure There Will Not be a Recurrence</p> <p>♦ Dietary Manager inserviced all dietary staff on November 9th and 10th relative to food procurement, storing, preparation and serving under sanitary conditions specifically as it relates to hand washing and glove change and cross contamination.</p> <p>♦ On November 10th glove distribution sites were limited to over the sink so as to require employees to be at the sink for washing during glove changes.</p> <p>♦ Daily monitoring for proper procedure of glove use, hand washing, cross contamination and equipment storage was added to the weekly cleaning/ monitoring schedule on November 15, 2010.</p> <p>♦ DON/licensed designee will inservice on December 9-11 of the responsibility of the nursing staff relative to food serving under sanitary conditions specifically as it relates to hand washing and glove change and cross contamination.</p> <p>Monitoring Changes To Assure Continuing Compliance</p>		

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F 371	Continued From page 5	F 371	<ul style="list-style-type: none"> ◆ <u>Dietary Manager will monitor daily sanitation schedule for compliance beginning November 15, 2010.</u> ◆ Monitoring for proper procedure of glove use and hand washing was added to the Monthly Dietary Quality Assurance Report (cross contamination and equipment storage are already incorporated in the existing report) beginning November 15, 2010. 	
F 441 SS=D	<p>During Interview with Dietary Aide #7 on 11/09/10 at 4:55 PM, she stated she had cross contaminated the plate covers and she was going to put the cover in the dish room.</p> <p>Interview with the Dietary Manager on 11/09/10 at 6:15 PM, revealed the staff were to wash their hands anytime they removed gloves or if their hands were dirty.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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</p>	F 441	<ul style="list-style-type: none"> ◆ Dietary Manager shall provide results of monthly Quality Assurance monitoring to the QA Committee at least quarterly x 2. QA Committee shall determine cessation or continuation based on compliance achieved. <p>Date of Completion: 12-13-10</p> <p>F441</p> <p>Immediate Corrective Action For Residents Found To Be Affected</p> <p>No specific resident(s) identified. However,</p> <ul style="list-style-type: none"> ◆ LPN #2 found to not wash her hands between glove changes during wound care was re-educated by the DON on November 10, 2010 which reviewed standard nursing practice and the facility's policy of washing hands after each change of gloves during wound care. ◆ Re-education was provided to SRNA #8 to review standard infection control practice and the facility policy to bag dirty linen as it is acquired for appropriate removal from 	

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F 441	<p>Continued From page 6</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens 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 and interview it was determined the facility failed to maintain an infection control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of disease and infection. Observation on Unit II revealed State Registered Nurse Aides (SRNA) putting soiled linens on the floor in resident rooms; leaving the ice scoop in the ice while passing ice. The wound care nurse did not wash her hands between glove changes during wound care.</p> <p>The findings include:</p> <p>1. Observation of wound care on 11/09/10 at 9:30 AM, revealed the Licensed Practical Nurse (LPN) to change her gloves three (3) times during the wound care but did not wash her hands with any of the glove changes.</p> <p>Interview with LPN #2 on 11/10/10 at 9:20 AM, revealed she had not washed her hands when she had changed gloves. She further stated not washing her hands could cause an infection in the</p>	F 441	<p>resident care area. This re-education was presented by the DON November 10, 2010.</p> <ul style="list-style-type: none"> Re-education was also provided to SRNA #9 that reviewed standard infection control practice and facility policy to place the ice scoop in the tray provided on the side of the ice cart at all times when not in use. This re-education was presented by the DON on November 10, 2010. <p>Identification of Other Residents With The Potential to be Affected</p> <ul style="list-style-type: none"> A review of the facilities Infection Control Program's tracking and trending report was completed by the DON/licensed designee on December 10th to identify any further breach of standard infection control practice. There were no resident's identified from this audit. Re-education was provided to the nursing staff 1) to bag dirty linen as it is acquired for appropriate removal from resident care area and 2) to place the ice scoop in the tray provided on the side of the ice cart at all times when not in use. This re-education was presented by the DON and Weekend Nurse Supervisor from November 10-14, 2010. <p>Measures Taken To Assure There Will Not be a Recurrence</p> <ul style="list-style-type: none"> Re-education was provided to the nursing staff to review standard infection control practice and the facility policy by the 	

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F 441	<p>Continued From page 7 wound.</p> <p>2. Observation of resident care on 11/10/10 at 9:45 AM, revealed the SRNA to put the soiled linens on the floor as she did the AM care.</p> <p>Interview with SRNA #8 on 11/10/10 at 9:45 AM revealed she knew not to put soiled linens on the floor as it could spread infection.</p> <p>Observation on Unit II on 11/10/10 at 10:17 AM, revealed while a SRNA was passing, she had left the ice scoop in the ice.</p> <p>Interview with SRNA #9 on 11/10/10 at 10:17 AM revealed she should have placed the ice scoop in the tray provided on the side of the cart.</p> <p>Interview with the LPN, Unit Manager for Unit II on 11/10/10 at 8:00 PM, revealed the LPN should have washed her hands after each glove change. Further interview revealed the SRNA should have bagged the linen and placed the ice scoop in the tray provided to help prevent the spread of infection.</p> <p>Review of the facility's policy for Clean Dressing Change dated 10/01/10, revealed staff were to wash and dry their hands each time gloves were removed.</p>	F 441	<p>DON/license designee from December 9-11, 2010.</p> <ul style="list-style-type: none"> ◆ Inservicing is being provided by the DON/licensed designee from December 9-11, 2010 for licensed staff on the facility's policy and standard nursing practice on proper technique when performing a clean dressing change including washing hands after each change of gloves. ◆ Licensed Staff will be required to successfully complete a skills check off competency for a clean dressing change observed by the Assistant DON/licensed designee by December 23, 2010 which will include appropriate hand washing technique after each change of gloves. ◆ Beginning December 20, 2010 newly hired nursing staff will receive education by the Assistant DON/licensed designee on standard infection control practices and the facilities Infection Control Policy during the initial new employee orientation as well as on the facilities policy for a "Clean Dressing Change" and will be required to successfully complete a skills check off competency on a clean dressing change with the Assistant DON/ licensed designee prior to being released to independent duty. ◆ Beginning December 20, 2010, the Assistant DON/licensed designee will keep a log of completed competencies. ◆ Infection Control Rounds will be completed by the Assistant DON/licensed designee 	

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			<p>beginning December 20, 2010 alternating units 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 2 months.</p> <ul style="list-style-type: none"> ◆ Any non-compliance will require immediate intervention as directed by the Assistant DON and staff re-education/discipline by the DON/jeff04<i>licensed designee as deemed appropriate by facility Administration.</i> ◆ licensed designee as deemed appropriate by facility Administration. <p>Monitoring Changes to Assure Continuing Compliance</p> <ul style="list-style-type: none"> ◆ The DON/licensed designee will complete monthly audits of the competencies to ensure timely compliance and performance concerns are appropriately addressed. ◆ The DON/licensed designee will complete daily audits x 2 weeks, then weekly x 4 weeks to: 1) ensure resident's rooms are free of soiled linens and; 2) monitor ice passes to ensure the ice scoops are placed in the tray provided on the side of the ice cart when not in use. ◆ <i>Infection Control Rounds will be completed by the Assistant DON/licensed designee beginning December 20, 2010 alternating units to ensure all other infection control practices are adequate to prevent the spread of infection. These rounds will</i> 	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188248	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/10/2010
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)	(X5) COMPLETION DATE
			<p><u>occur weekly x 4 weeks; then every 2 weeks x 4 weeks, then monthly x 2 months.</u></p> <ul style="list-style-type: none"> ◆ Results of the audits will be submitted to the Quality Assurance committee for review at least quarterly and revision until the Quality Assurance committee has determined 100% compliance is achieved ◆ Any area of non-compliance will require re-education by the DON/licensed designee, increased monitoring, and revision to the plan as deemed appropriate by the Quality Assurance committee to ensure 100% compliance. <p>Date of Completion:</p>	12-24-10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185248	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/09/2010
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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 018	Continued From page 1 deficient practice has the potential to affect staff and all twenty (20) residents. The facility has the capacity for one hundred and nine (109) beds and at the time of the survey the census was one hundred and seven (107). The findings include: Observation on 11/09/10 at 10:00 AM revealed upon the testing and inspection of one (1) fire door, the door failed to close all the way to resist the passage of smoke as required. This was confirmed by the Maintenance Director. Interview with the Maintenance Director on 11/09/10 at 10:00 AM, revealed he had just checked all the fire doors recently and all had worked fine. NFPA Standard: NFPA 101, 19.3.6.3.1 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.	K 018	all doors closed and sealed properly on inspection. ♦ Corridor fire doors will be added to weekly Maintenance Quality Assurance Inspection Report beginning December 13, 2010 to assure proper closer and seal. Monitoring Changes To Assure Continuing Compliance ♦ Maintenance Director/designee inspection report shall be submitted to the Quality Assurance Committee for review and revision until the Quality Assurance committee has determined 100% compliance is achieved. Date of Completion:	12-13-10
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in	K 025	K025 Immediate Corrective Action For Residents Found To Be Affected No specific resident(s) identified. However, Maintenance Director performed visual check of	

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K 025	<p>Continued From page 2</p> <p>accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke barriers were an approved type according to NFPA standards.</p> <p>The findings include: Observation of the attic space on 11/09/10 at 11:30 AM, revealed the attic space smoke barriers could not be visually seen to confirm that smoke barriers exist. Observation of one (1) smoke barrier was confirmed in the administration office attic access. The Code requires that smoke barriers be continuous through all concealed spaces for the purpose of restricting the movement of smoke. This was confirmed by the Maintenance Director.</p> <p>Interview on 11/09/10 at 11:30 AM, with the Maintenance Director, revealed he was not able to crawl through the attic to get to these walls because the space was too small.</p> <p>NFPA 101 2000 Edition 8.3.1* General. Where required by Chapters 12 through 42,</p>	K 025	<p>all smoke barrier walls on December 03, 2010 with no breeches noted. Thus no resident would have been affected by this practice.</p> <p>Identification of Other Residents With The Potential to be Affected</p> <p>Maintenance Director performed visual inspection of all smoke barrier walls on December 03, 2010 with no breeches noted. Thus no residents identified.</p> <p>Measures Taken To Assure There Will Not be a Recurrence</p> <ul style="list-style-type: none"> ◆ Contracted with architectural firm to perform visual inspection on December 9, 2010 and provide written documentation and recommendations, if any, for correction in order to comply with current Life Safety Code. Contracts, if any, will be secured as soon as practical after documentation is provided. ◆ Inspection of Smoke Barrier Walls shall be added to Maintenance Quarterly Quality Assurance Report beginning December 9, 2010. <p>Monitoring Changes To Assure Continuing Compliance</p> <ul style="list-style-type: none"> ◆ Maintenance Director/designee inspection report shall be submitted to the Quality Assurance Committee quarterly for review and revision until the Quality Assurance committee has determined 100% compliance is achieved. 	
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NAME OF PROVIDER OR SUPPLIER SAYRE CHRISTIAN VILLAGE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3840 GAMELOT DRIVE LEXINGTON, KY 40517	
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K 025	Continued From page 3 smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of	K 025	Date of Completion:	12-24-10
K 038 SS=D	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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that exits were properly marked according to NFPA standards.	K 038	K038 Immediate Corrective Action For Residents Found To Be Affected No specific resident(s) identified. However, ♦ Maintenance Director indicated there was no negative effect on any resident located within the immediate area at the time the survey was conducted. Blinds were removed by Maintenance director on November 09, 2010.	

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K 038	Continued From page 4 The findings include: Observation on 11/09/10 at 10:10 AM, revealed the facility had delayed egress locks on an exit door leading from the Unit #1 lounge to the outside. Further observation revealed an adjustable blind was installed on the door blocking the signage on the door indicating such. This was confirmed by the Director of Maintenance during the observations. Exits are to be readily accessible at all times. Interview on 11/09/10 at 10:10 AM, with the Director of Maintenance, revealed that they were trying to block the sunlight coming in during a specific time of day and thought it would be allowable. Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in	K 038	Identification of Other Residents With The Potential to be Affected ♦ An audit of all fire exit doors was performed by Maintenance Director on November 09, 2010, with no other doors identified as being effected, thus no other residents were identified. Measures Taken To Assure There Will Not be a Recurrence ♦ Exit fire doors will be added to weekly Maintenance Quality Assurance Inspection Report beginning December 13, 2010 to assure that fire exits are readily accessible at all times. Monitoring Changes to Assure Continuing Compliance ♦ Maintenance Director/designee inspection report shall be submitted to the Quality Assurance Committee for review and revision until the Quality Assurance committee has determined 100% compliance is achieved. Date of Completion:	12-13-10

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K 038	Continued From page 5 accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101 LIFE SAFETY CODE STANDARD	K 038		
K 072 SS=F	Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access according to NFPA standards.	K 072	K072 Immediate Corrective Action For Residents Found To Be Affected No specific resident(s) identified. However, ♦ Maintenance Director removed linen carts and lifts from the areas identified on November 09, 2010. Identification of Other Residents With The Potential to be Affected ♦ All means of egress were inspected by Maintenance Director on November 09, 2010 to identify any other areas that might be affected by this practice. Those areas identified were corrected immediately. Measures Taken To Assure There Will Not be a Recurrence ♦ Linen carts were permanently removed from the facility by the	

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K 072	Continued From page 6 The findings include: Observations on 11/09/10 at 9:23 AM, revealed linen carts were stored outside of rooms 111 and 129. Further observation revealed patient lifts were also being stored outside of rooms 117 and 125 in the corridor/hallway. This was confirmed by the Maintenance Director. Interview with the Maintenance Director on 11/09/10 at 9:23 AM, revealed the linen carts and patient lifts were stored there because the facility did not have any other place to put them. NFPA Standard: 19.2.3.3* Any required aisle, corridor, or ramp shall be not less than 4 ft (1.2 m) in clear width where serving as means of egress from patient sleeping rooms. The aisle, corridor, or ramp shall be arranged to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers. Exception No. 1: Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (112 cm) in clear and unobstructed width. Exception No. 2: Exit access within a room or suite of rooms complying with the requirements of 19.2.5.	K 072	Housekeeping/Laundry Supervisor on November 09, 2010. ♦ Lifts were stored in identified areas by Maintenance Director on November 09, 2010. ♦ DON/licensed designee will inservice on December 9-11 of the responsibility of the licensed staff to assure that means of egress remain free of all obstructions and impediments in case of fire or other emergency. ♦ Means of egress will be added to weekly Maintenance Quality Assurance Inspection Report beginning December 13, 2010 to assure that means of egress remain free of all obstructions and impediments in case of fire or other emergency. Monitoring Changes To Assure Continuing Compliance ♦ Maintenance Director/designee inspection report shall be submitted to the Quality Assurance Committee for review and revision until the Quality Assurance committee has determined 100% compliance is achieved.		
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4	K 073	Date of Completion: K073 Immediate Corrective Action For Residents Found To Be Affected	12-13-10	

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K 073	<p>Continued From page 7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure decorations used in the facility were flame retardant, according to NFPA standards. The deficiency affected approximately one hundred and seven (107) residents. The facility is licensed for one hundred and nine (109) beds and the census the day of survey was one hundred and seven (107).</p> <p>The findings include:</p> <p>Observation on 11/09/10 at 9:02 AM, revealed decorations (wreaths) on resident room doors located in the facility. The resident rooms were: number: 102,105,106,109,111,113,114,115,117,119,120,121,122,125,126,130,135,136,137,138,139,140,141,143,144,145,146,148,150,152,155,156,158,159. Combustible decorations used in a health care facility must be flame retardant to prevent the spread of fire. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 11/09/10 at 9:02 AM, with the Maintenance Director, revealed the facility does not treat decorations to make them flame retardant.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.5.4 Combustible decorations shall be prohibited in any Health care occupancy unless they are flame-retardant. Exception: Combustible decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or</p>	K 073	<p>No specific resident(s) identified. However,</p> <ul style="list-style-type: none"> ◆ Maintenance staff retained or treated wreaths with fire retardant, logged and tagged item on December 01, 2010. ◆ All remaining decorations were treated, logged and tagged by Maintenance staff by December 03, 2010. <p>Identification of Other Residents With The Potential to be Affected</p> <p>A review of the resident's decorations was performed by maintenance staff from November 10 through November 30 to identify any resident which may have been affected. There were no additional residents identified.</p> <p>Measures Taken To Assure There Will Not be a Recurrence</p> <ul style="list-style-type: none"> ◆ Letter to resident's and families was mailed on December 03, 2010 by facility administrator outlining requirements for compliance with assuring that no furnishings or decorations of highly flammable character are used. ◆ Any flammable decoration or furnishing with no flame retardant label or identification and that is unable to be treated with a flame retardant treatment will be removed by the resident or family by December 15, 2010. ◆ Any noncompliant items identified after December 15, 2010 will be removed by 	

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K 073 K 147 SS=F	Continued From page 8 spread is not present. NFFA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFFA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to guard against accidental contact of live parts per NFFA Standard. The findings include: Observation revealed the electrical panel box in the corridors of Unit #1 Nurses Station and Unit # 2 Nurses Station were not secured. This deficiency has the potential to affect all four (4) smoke compartments, staff and one hundred and seven (107) residents. Interview on 11/09/10 at 9:45 AM, with the Maintenance Director, revealed he was unaware the electrical panels should be secured. Reference: NFFA 70 (1999 Edition), 110.27 Guarding of Live Parts. (A) Live Parts Guarded Against Accidental Contact. Except as elsewhere required or permitted by this Code, live parts of electrical equipment operating at 50 volts or more shall be guarded against accidental contact by approved enclosures or by any of the following means: (1) By location in a room, vault, or similar enclosure that is accessible only to qualified	K 073 K 147	facility staff and stored for no more than 30 days. Social Services will notify appropriate parties to pickup these items. ♦ Staff will be inserviced on December 9-11 by each Department Manager of the requirement to assure that no furnishings or decorations of highly flammable character are used. Monitoring Changes To Assure Continuing Compliance ♦ Maintenance Director/designee inspection report shall be submitted to the Quality Assurance Committee for review and revision until the Quality Assurance committee has determined 100% compliance is achieved. Date of Completion: 12-24-10 K147 Immediate Corrective Action For Residents Found To Be Affected No specific resident(s) identified. However, ♦ Maintenance Director indicated there was no negative effect on any resident located within the immediate area at the time the survey was conducted. Electrical panel locks were secured by Maintenance Director on November 10, 2010.	

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K 147	Continued From page 9 persons. (2) By suitable permanent, substantial partitions or screens arranged so that only qualified persons have access to the space within reach of the live parts. Any openings in such partitions or screens shall be sized and located so that persons are not likely to come into accidental contact with the live parts or to bring conducting objects into contact with them. (3) By location on a suitable balcony, gallery, or platform elevated and arranged so as to exclude unqualified persons. (4) By elevation of 2.5 m (8 ft) or more above the floor or other working surface. (B) Prevent Physical Damage. In locations where electric equipment is likely to be exposed to physical damage, enclosures or guards shall be so arranged and of such strength as to prevent such damage. (C) Warning Signs. Entrances to rooms and other guarded locations that contain exposed live parts shall be marked with conspicuous warning signs forbidding unqualified persons to enter.	K 147	<p>Identification of Other Residents With The Potential to be Affected</p> <ul style="list-style-type: none"> All electrical panels were inspected by Maintenance Director on November 09, 2010 to identify any other areas that might be affected by this practice. No other areas were identified thus no other residents were identified. <p>Measures Taken To Assure There Will Not be a Recurrence</p> <ul style="list-style-type: none"> Electrical panels will be added to weekly Maintenance Quality Assurance Inspection Report beginning December 13, 2010 to assure all are secured against accidental contact. <p>Monitoring Changes To Assure Continuing Compliance</p> <ul style="list-style-type: none"> Maintenance Director/designee inspection report shall be submitted to the Quality Assurance Committee for review and revision until the Quality Assurance committee has determined 100% compliance is achieved. <p>Date of Completion:</p>	12-13-10