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

PRINTED: 02/03/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185248		01/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYRE CHRISTIAN VILLAGE NURSING HOME	3840 CAMELOT DRIVE LEXINGTON, KY 40517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey was initiated on 01/17/12 and concluded on 01/20/12. Deficiencies were cited, with the highest scope and severity of a "D."	F 000	**Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.**	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policies, it was determined the facility failed to meet professional standards of quality by failing to ensure Physician's medication orders were carried out for two (2) of twenty-three (23) residents, (Resident #1 and Resident #17). The facility failed to accurately carry out Resident #1's Physician's order for Augmentin (an antibiotic ordered for bronchitis) twice a day, for seven (7) days. Per the original physician order the medication would have been administered beginning the evening of 01/03/12 and discontinued after the morning dose on 01/10/12. However, the medication was continued past the stop date and the resident received a dose the evening of 01/11/12 and the morning and evening on 01/12/12. The facility failed to accurately carry out Resident #17's Physician's order for Donepezil (used to treat dementia of the Alzheimer's disease type) by administering the drug in the morning instead of the evening as prescribed.	F 281	**F281 SERVICES MEET PROFESSIONAL STANDARDS** **Targeted Residents** On 01/18/12, the Unit Manager of Unit 1 notified the Physician's Assistant of the time administration error for the Aricept order on Resident #17. An order was received at that time to give the medication at HS (Hour of Sleep). A telephone order was completed by the Unit Manager, who also posted it to the MAR (Medication Administration Record). The telephone order transcription and the transcription to the MAR were reviewed by the charge nurse for accuracy. The medication has been given at HS since that date. Resident #17 has experienced no complications from the change in medication administration time. On 01/18/12, the Unit Manager of Unit 2 contacted the Physician's Assistant to discuss Resident #1's order for Augmentin written	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ann Phillips
TITLE: Administrator
(X6) DATE: 2-10-12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185248		01/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYRE CHRISTIAN VILLAGE NURSING HOME	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 281	Continued From page 1 The findings include: Review of the Facility's Policy, "Physician Medication Orders", with the implementation date of 06/15/11, revealed orders for medications must include: specific duration of therapy and frequency of administration. 1. Record review revealed the facility admitted Resident #1 on 01/25/08 with diagnoses which included Dementia and Functional Decline and a recent diagnosis of Upper Respiratory Infection and Bronchitis. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 11/18/11, revealed the facility assessed the resident as having moderate impairment during a Brief Interview for Mental Status (BIMS) assessment. Review Resident #1's Physician's Telephone Orders, dated 01/03/12, revealed an order for an oral dose of Augmentin (an antibiotic ordered for treatment of upper respiratory infection/bronchitis) to be given twice a day, for seven (7) days. Review of the Medication Administration Record (MAR) for 01/12 revealed Resident #1 received the first dose of Augmentin at 9:00 PM on 01/03/12. Further review revealed the words "STOP" and "X" indicating the drug was discontinued and not to be given at 9:00 PM 1/10/12 and 9:00AM and 9:00PM on 1/11/12, however, initials were also noted in the same documented area indicating the drug had been administered during those doses.	F 281	on 01/03/12 which was to be administered BID x 7 days. This antibiotic required an extension of administration dates to ensure she received the full course of antibiotic due to 3 refusals during the initial course of treatment. An order was not transcribed to extend the administration dates. The PA stated that extension of the dates to ensure the resident received all doses was the prudent action to take and would have given that order. A clarification order was written on 01/18/12 to cover the extended time frame. The antibiotic was prescribed for treatment of an Upper Respiratory Infection. The resident received all 14 doses between the dates of 01/03/12 and 01/11/12 and has experienced no complications since the completion of this medication. **Identification of other residents** All residents have the potential to be affected. An audit was performed by members of the Nursing management team including Unit Managers, Assistant Director of Nursing, Restorative Nurse, Quality Assurance Nurse, Staff Development Coordinator and Weekend House Supervisor beginning 02/06/12 and completed on 02/10/12. This audit included review of all residents physician orders with comparison to all new or re-admit orders, telephone orders, and any consultant recommendations including pharmacy and psychiatric for the past 30 days. The audit also included a review of all time limited orders to ensure they were carried out as ordered. Any discrepancies found will be reviewed with the physician with new orders followed as indicated per facility's "Medication Order"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185248		01/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYRE CHRISTIAN VILLAGE NURSING HOME	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 281	Continued From page 2 Interview, on 01/18/12 at 4:00PM, with Licensed Practical Nurse #1, revealed she gave the 9:00 AM dose on 01/11/12. Further interview revealed she would not have given the dose if the "STOP" had been recorded in the dosing time slot the day she had administered the medication. She could not state who or when the "STOP" would have been written on the MAR, only that it appeared to have been written after three additional doses of medication had been administered. Interview with Unit Coordinator #1, on 01/18/12 at 4:02PM, revealed it appeared three (3) doses were given beyond the original stop date of the antibiotic ordered for Resident #1. Continued interview revealed she did not know when or why the drug was extended unless a nurse called the practitioner to get an extension of the dosing, however she could find no documented evidence in the chart to indicate an extension was requested or ordered for the medication. She further stated she was not aware the facility had failed to ensure the original medication orders were carried out and the medication stopped after seven (7) days. She also acknowledged the nurse who received the telephone order failed to mark the stop time on the MAR when the medication order was written. 2. Record review revealed Resident #17 was admitted to the facility on 06/17/11 with diagnoses which included Alzheimer's Disease, Dementia, Anxiety, Depression and Depressive Disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 12/02/11, revealed the facility assessed the resident as having severe impairment during a Brief Interview for Mental	F 281	policy. **Systemic Changes** An in-service for Licensed Nurses and KMA's was presented beginning 02/08/12 through 02/11/12 by the Director of Nursing, Staff Development Coordinator and Assistant Director of Nursing reviewing the standard practice for taking orders from a physician, appropriate transcription to MAR/TAR, and of necessary interventions to follow when carrying orders out including procedure for reporting refusals and extending time limited orders. An addendum was made to the facility's "Physician Medication Orders" policy to include a requirement for all MD orders and transcription to MARs or TARs to have a 2nd check by an additional licensed staff member and initialed to indicate that the 2nd check was completed and transcription was accurate. The Staff Development Nurse and Quality Assurance Nurse in-serviced this new requirement to Licensed staff and KMA's from 02/03/12 through 02/10/12. **Monitoring** The Quality Assurance Nurse receives a copy of all physician orders and reviews to ensure 2nd check initials are present. If a 2nd check is not evident on any order, the Quality Assurance Nurse will complete the 2nd check and re-educate the nurse who received the order on the Physician Medication Order Policy addendum and expectation of compliance. The Quality Assurance Nurse is completing audits of time limited orders to ensure they are being followed as prescribed with appropriate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185248	A. BUILDING B. WING	01/20/2012

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
F 281	Continued From page 3 Status (SIMS). Review of the Package Insert of the medication Donepezil revealed, "DOSAGE AND ADMINISTRATION- ARICEPT [Donepezil] should be taken in the evening, just prior to retiring." Review of Resident #17's Physician's Telephone Orders, dated 11/27/11, revealed an order to "change time" of Donepezil tablet to "every AM". However, the medication was already being administered in the AM so this order did not accurately reflect any change of administration time. Review of i?esident #17's Nurse's Notes, dated 11/28/1'l, n.::vealed a new order was received to change the administration time of the resident's medicatior, of Donepezil from 8:00AM to bedtime (8:00PM). Review of the November and December's Medication Administration Records (MARs) revealed Resident #17 had an order for Donepezil onc;e daily with the administration time of 8:00 AM. Further review of the MAR revealed a revision to the order related to dosing change on 11/29/11 with the 8:00AM time changed to 8:00 PM (bedtime). The records reflected Resident #17 received the medication at 8:00 PM (bedtime) as ordered from 11/29/11 through 12/31/11. Record review of the January 2012 MAR revealed the Donepezil was given at 8:00AM instead of 8:00PM.	F 281	nursing intervention for refusals and extension of order as indicated. These audits will be performed weekly x 1 month, then every 2 weeks x 1 month, and then monthly x 1 month. Any area of non-compliance found during the audits will require re-education by the Director of Nursing or other administrative staff, increased monitoring, and revision to the plan as deemed appropriate by the Quality Assurance committee. Results of the audits will be submitted to the Quality Assurance committee for review and revision until the Quality Assurance committee has determined 100% compliance has been achieved.	02/15/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185248		01/20/2012

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
F 281	Continued From page 4 Interview, on 01/20/12 at 2:00PM, with Unit Coordinator #2, revealed the medication should be given at bedtime. She further stated she had failed to accurately transcribe the order to reflect the change in administration time from 8:00AM to be given at 8:00 PM. Therefore, in January 2012, when the new month's MAR's were checked against recent Physician's orders the time was incorrectly noted to be 8:00AM instead of the intended time of 8:00 PM which resulted in the Physician's orders not being carried out as recommended and requested.	F 281		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it- (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	**F441 INFECTION CONTROL** **Targeted Residents** The SRNA found to not be practicing appropriate hand hygiene during meal service was re-educated by the Assistant Director of Nursing on 01/25/12. She reviewed the facility's policy on "Handwashing / Hand Hygiene" which includes before and after direct resident contact and before and after assisting a resident with meals. **Identification of other residents** All residents have the potential to be affected. A review of the facilities Infection Control Program's tracking and trending report was completed by the Assistant Director of Nursing to identify any further breach of standard infection control practice. There were no findings to indicate any resident had been affected by this practice. **Systemic Changes** An in-service for nursing staff was presented beginning 02/08/12 through 02/11/12 by the Director of Nursing, Staff Development	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185248		01/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYRE CHRISTIAN VILLAGE NURSING HOME	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 441	Continued From page 5 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's polices, it was determined the facility failed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection as evidenced by State Registered Nurse Aide (SRNA) #7 making contact with multiple residents at the conclusion of the evening meal service without sanitizing her hands between resident contact of Unsampled Residents #1, #2, and #3. The findings include: Review of the facility's policy, Meal Service, dated 1/10/10, revealed the facility policy is to ensure each resident receives the amount of assistance necessary during meal service, including positioning the resident to maintain comfort and assisting the resident with eating. Review of the facility's policy, Infection Control	F 441	Coordinator and Assistant Director of Nursing to re-educate on the facility's Infection Control Policy which supports standard infection control practice. This in-service included the review of the acceptable practice of Hand Hygiene. Nursing staff will be required to successfully pass an exam on acceptable infection control practices immediately following the in-service to ensure comprehension and future compliance with this policy. Newly hired nursing staff will receive education by SDC on the facilities Infection Control Policy including the acceptable practice of Hand Hygiene during new employee orientation. **Monitoring** The DON and assigned department managers will complete daily audits x 2 weeks, then weekly x 4 weeks to ensure staff are practicing appropriate hand hygiene during meal services. Infection Control Rounds will be completed by the Assistant Director of Nursing to ensure all other infection control practices are adequate to prevent the spread of infection. These rounds will occur weekly x 4 weeks, then every 2 weeks x 4 weeks, then monthly x 2 months. Any non-compliance found during the audits or rounds will require immediate corrective action by the Director of Nursing or other member of nursing management as deemed appropriate by facility Administration.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185248		01/20/2012

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
F 441	Continued From page 6 Program, dated 10/07, revealed the facility program will develop control measures to protect residents and personnel from institution-acquired infections. Review of the facility's policy, Handwashing/Hand Hygiene, implementation date 10/01/10, revealed the facility considers hand hygiene the primary means to prevent the spread of infections. The policy states all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. The policy further states employees must wash their hands under the following conditions, including before and after assisting a resident with meals, before and after direct contact with residents or objects/medical equipment in the immediate vicinity of the resident. Observation of the Dining Area located behind the Nurses' Station, on 01/18/12 at 5:30PM, revealed SRNA #7 having direct resident contact as she assisted Unsampled Resident #1 with eating. A second unsampled resident seated in a wheelchair was noted to have finished his/her meal and had attempted to self propel away from dining table. Without sanitizing her hands the SRNA was observed to reposition Unsampled Resident #2 which included contact with the resident's clothing, wheelchair and skin. Continued observation revealed, without sanitizing her hands, SRNA #7 provided intervention to Unsampled Resident #3who attempted to get out of his/her wheelchair. SRNA #7 was observed to have her hands in direct contact with Unsampled Resident #3's hands, clothing and wheelchair. Observation again	F 441	Results of the audits and rounds will be submitted to the Quality Assurance committee for review and revision until the Quality Assurance committee has determined 100% compliance has been achieved.	02/15/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185248		01/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYRE CHRISTIAN VILLAGE NURSING HOME	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 441	Continued From page 7 revealed, without sanitizing her hands, SRNA #7 provided intervention to Unsampled Resident #2 by assisting him/her from the Dining Area by pushing the resident's wheelchair. Interview, on 1/20/12 at 2:40 PM, with SRNA #7 revealed she had been trained on proper handwashing/sanitizing. She further stated she failed to wash her hands because of the urgency to assist the residents with their immediate needs. Interview, on 01/20/12 at 2:50 PM, with the Supervisor of SRNA #7 revealed SRNA's are trained in orientation and re-trained as necessary. The Supervisor stated staff was to provide restorative dining care and follow the facility's policy by sanitizing hands between assisting residents.	F 441		

Acceptable HC 2/15/12 as by about LSC

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

PRINTED: 02/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185248	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/19/2012

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
K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1982 Survey under: NFPA 101 (2000 Edition), Chapter 19 (existing health care) Facility type: SNF/NF Smoke Compartment: 5 Fire Alarm: Complete fire alarm Sprinkler System: Complete automatic sprinkler system A standard Life Safety Code survey was conducted on 01/19/2012. Sayre Christain Village Nursing Home was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The following demonstrate non compliance:	K000	**Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.**	
K 045 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K045	**K045** **NFPA 101 LIFE SAFETY CODE STANDARD** **Targeted Residents** No Residents were directly affected by this practice although the facility realizes that there was a potential to affect seventy four (74) residents, staff and visitors. A two bulb fixture was installed outside of # 2 door on 1/29/12. A two bulb fixture was installed outside of doors #3 and #4 on 1/19/12. A two bulb fixture was installed outside of door #11 on 2/3/12. An audit was performed by the Maintenance Director on 1/19/12 where he	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ann Phillips
TITLE: Administrator
(X6) DATE: 2-10-12

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ner safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185248	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/19/2012

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
K 045	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, four (4) of six (6) exterior exits, seventy four (74) residents, staff and visitors. The findings include: Observation, on 01/19/2012 at 10:23 AM, revealed the exterior exit of exit two (2) was equipped with a single bulb for illuminating the public way from the exit. Exit lighting must be arranged so the failure of a single bulb will not leave the exit in complete darkness. During the survey the same was found for exits three (3), four (4) and eleven (11). The observation was confirmed with the Maintenance Director. Interview, on 01/19/2012 at 10:23 AM, revealed he/she was unaware the lighting fixtures serving the exterior exits must include more than one bulb. Reference: NFPA 101 (2000 edition) Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K045	also identified door #10 with a single bulb fixture. On 1/27/12 a two bulb fixture was installed outside of door #10. No other doors were found to have only one bulb fixtures **Identification of Other Residents** Seventy four (74) residents, visitors and staff had the potential to be affected by this practice. **Systemic Changes** An all staff in-service was given by the Administrator where she reviewed the K045 Life Safety Regulation and that all doors would be audited and any found with only one bulb fixtures would be changed to two bulb fixtures. This in-service was held on 1/25/12, 1/26/12 and 1/28/12. The Safety Team met on 1/31/12 to discuss K045 regulation and a listing of top cited Ktags were given out and reviewed. The Life Safety Code Team will conduct monthly outside rounds to ensure facility stays in compliance with K045. **Monitoring** Any issues/concerns found through the Life Safety Code Team will be brought to the Quality Assurance Committee for three months for monitoring.	02/15/12
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K056	**K056** **NFPA 101 LIFE SAFETY CODE STANDARD**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185248	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/19/2012

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
K 056	Continued From page 2 If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure complete sprinkler coverage, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, thirty two (32) residents, staff and visitors. The findings include: Observation, on 01/19/2012 at 10:25 AM, revealed the canopy located at exterior of Exit Two (2) was not protected by sprinkler coverage. The canopy was constructed of wood. Any exterior roof or canopy larger than four (4) feet in width constructed of combustible materials must be sprinkler protected. The observation was confirmed with the Maintenance Director. Interview, on 01/19/2012 at 10:25 AM, with the	K056	**Targeted Residents** No Residents were directly affected by this practice although the facility realizes that there was a potential to affect thirty two (32) residents, staff and visitors. On 1/27/12 Brown Sprinkler installed sprinkler protected equipment to door #2. On 1/19/12 an audit was performed by the Maintenance Director and no other issues/concerns were found. **Identification of Other Residents** Thirty Two (32) residents, visitors and staff had the potential to be affected by this practice. **Systemic Changes** An all staff in-service was given by the Administrator where she reviewed the K056 Life Safety Regulation and explained that all doors would be audited and any found with with an exterior roof or canopy over 4 feet in width with combustible equipment would have to be sprinkler protected. This in-service was held on 1/25/12, 1/26/12 and 1/28/12. The Safety Team met on 1/31/12 to discuss K056 regulation and a listing of top cited Ktags were given out and reviewed. The Life Safety Code Team will conduct monthly outside rounds to ensure facility stays in compliance with K056. **Monitoring** Any issues/concerns found through the Life Safety Code Team will be brought to the Quality Assurance Committee for three months for monitoring.	02/15/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185248	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAYRE CHRISTIAN VILLAGE NURSING HOME	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
K 056	Continued From page 3 Maintenance Director, revealed he was unaware of the requirment for the area to be sprinkler protected. Reference: NFPA 13 (1999 edition) 5-13.8.1. Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056		