

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

PRINTED: 10/18/2011
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 10/07/2011
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 000 F 282 SS=D	<p>INITIAL COMMENTS</p> <p>An abbreviated survey investigating ARO #KY00017142 was initiated on 10/07/11 and concluded on 10/07/11. ARO#KY00017142 was substantiated with deficiencies cited at 42 CFR 483.20 (F-282) with a scope and severity of a "D". 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 one (1) of three (3) sampled residents, (Resident #1). The facility failed to ensure the Plan of Care for Resident #1 was followed related to transfer assist of two (2) at all times.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #1 on 12/17/10 with diagnoses which included Dementia with Behavior Disturbances, Debility, Rheumatoid Arthritis, Osteoporosis and Diabetes Type II.</p> <p>Observation of Resident #1, on 10/07/11 at 10:15 AM, revealed Resident #1 was oriented to name only and refused to have covers removed for surveyor observations.</p>	F 000 F 282	<p>F 282 <u>Corrective Actions for Targeted Residents:</u> On September 12, 2011 resident #1 was assessed by Denine Collins, LPN, Unit Manager and Jennifer Hardin, PA. After her assessment of the bruising and edema, the PA gave the order to send Ms. Snowden to the Emergency Room for further evaluation. The facility immediately began an investigation to determine the root cause. Interviews were conducted with the resident, the SRNA responsible for her care and other staff who were involved in the care of Mrs. Snowden that day.</p> <p>The SRNA, Jalessa Cox admitted to transferring the resident by herself in full knowledge of her care planned transfer status being assist of 2 and had a copy of the SRNA assignment sheet in her pocket which clearly stated that Mrs. Snowden was to be transferred with the assist of 2 staff. The resident could not state how the bruising occurred. The SRNA's employing agency was immediately notified of the incident and was told that she would not be permitted to return to our facility. Ms. Cox had been previously educated and tested by her employing agency on February 16, 2011 on both Core I and Core II mandatory competencies for SRNA's which included Patient Safety goals and assessment of SRNA skills. Ms. Cox also completed and signed our facilities orientation that includes our Abuse Prohibition Policy and</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

Ann Phillip

TITLE

Administration 10/28/11

(X6) DATE

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>Review of Comprehensive Care Plan, with no date, revealed staff was to ensure appropriate assistance was provided for care and mobility. Review of the Resident Daily Care Plan (which State Registered Nurse Assistant (SRNA) carried in their pockets), dated 09/2011, revealed that prior to 09/13/11, Res. Ident #1 was to be a (2) person transfer. After 09/13/11, Resident #1 was to be transferred using a Hoyer lift per physician's order dated 09/13/11.</p> <p>Review of Nurses Notes, dated 09/12/11 at 2:00 PM, revealed Resident #1 had complained of right ankle pain and was noted to left sided facial bruising.</p> <p>Interview with SRNA#6, on 10/07/11 at 4:10PM, revealed she had cared for Resident #1 that day (09/12/11) and knew Resident #1 was a (2) person transfer but she was running behind and transferred him/her by herself. She further stated she did not recall any injuries occurring during the one (1) person assisted transfer, but noticed the bruising later in the shift.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 10/07/11 at 9:50AM, revealed the facility had not had any previous incidents with the SRNA in question, she had been in-serviced on appropriate assistance with transfers, and co-workers said she had always asked for help when needed.</p>	F 282	<p>Accidents and Supervision which covers following the residents care plan and safety procedures. This training was completed by the Assistant Director of Nursing on September 2, 2011.</p> <p>All parties were notified, including police, OIG and APS. The resident returned from the Emergency Room that evening with all findings negative for fractures or injury's requiring change to her care plan. She remained in bed until the following morning of September 13, 2011 when the Unit Manager, Denine Collins re-evaluated the residents transfer status and determined the need for a Hoyer lift for safe transfers based on the bruising of the right lower extremity. An order for the Hoyer lift was obtained at that time. The Emergency Room physician recommended follow-up with an Orthopedist which took place on September 19, 2011. On September 23, 2011 an order was received to cancel further follow-up with orthopedics as her general practitioner could manage her care from there forward. Mrs. Snowden displayed no negative response to the event and remains at her mental and physical baseline.</p> <p>Identification of Other Residents with Potential to Be Affected: All residents had the potential to be affected, but no others were identified.</p> <p>Systemic Changes: On September 13, 2011 through September 19, 2011, the facility staff were re-in-serviced by the Assistant Director of Nursing, the Weekend House Supervisor, the Director of Nursing and Unit Managers on Safe Transfers, following the care plan, Abuse/Neglect and Accidents and</p>		

Supervision. To further ensure safe and accurate practices continue, the transfer status of all residents were re-evaluated by the Unit Managers beginning September 16 and completed September 20, 2011. In addition, a care plan audit comparing comprehensive with SRNA Care Plan and assignments sheets was performed by the Unit Managers, RAI Coordinators, the Restorative Nurse, Clinical IT Nurse, Assistant Director of Nursing and Weekend House Supervisor beginning October 18 and was completed October 20, 2011.

Monitoring: On September 21, 2011, Unit Managers began performing random audits observing SRNA's during resident transfers to ensure they were performing safe transfers according to individual care planned interventions. These audits included ensuring each SRNA had a SRNA assignment sheet in their pocket for quick reference. The audits began with 2 observations per shift every day for 1 week from September 21 through September 27, 2011 then 1x per shift every day for an additional week from September 28 through October 4, 2011. On October 5, 2011, the audits continued for 1 observation every shift 3 days a week and are ongoing to date.

In addition, audits of residents care planned interventions is completed every shift 3 x a week to ensure these interventions are carried consistently as care planned.

The results of these audits are being submitted to the monthly QA Team consisting of The Medical Director, Nursing Home Administrator, Director of Nursing, Director of Social Services, Assistant Director of Nursing, Pharmacy Consultant and the Therapy Director for their review and recommendations as indicated.

Completion Date: November 4, 2011