

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

PRINTED: 11/15/2012  
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 10/29/2012
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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
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F 000 INITIAL COMMENTS

An Abbreviated Survey investigating KY#00019253 was initiated on 10/29/12 and completed on 10/30/12. KY#00019253 was unsubstantiated with no deficiencies cited. An unrelated deficiency was issued.

F 226 483.13(c) DEVELOP/IMPLEMENT ss D ABUSE/NEGLECT, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:

Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to immediately report one (1) allegation of misappropriation for one (1) of four (4) sampled residents (Resident #2). The facility failed to start the investigation of Resident #2's missing gold wedding band and a gold band with a diamond in the middle and failed to immediately report an allegation of misappropriation of Resident #2's property to the State Agencies.

The findings include:

Review of the facility's policy, "Abuse Prohibition and Control", revision date 08/19/11, revealed the purpose was to provide a safe environment that was free of abuse neglect, mistreatment involuntary seclusion, corporal punishment and misappropriation of property for all residents and

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Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.

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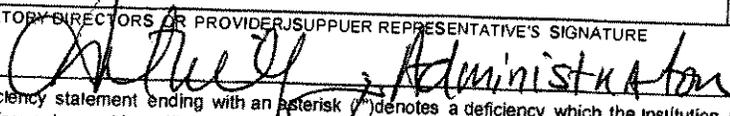
**F226D**  
Develop/Implement Abuse/Neglect ETC Policies

*Targeted Residents*

On 10-29-12 and 10-30-12 the Social Services Director extended and completed the investigation of resident #2's missing rings. The investigation was forwarded in to the OIG, reported to Adult Protective Services and to the local Police Department. The facility was unable to conclude what happened to the rings and as of this date have not been able to locate them.

*Identification of Other Residents*

On 10-29-12 one other resident was found to have some missing clothing and blanket from approximately 6 months ago. The facility completed a report and sent it in to

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11/24/12
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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 60 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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185248

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

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10/29/2012

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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(X5)  
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to ensure compliance with state and federal regulations. Under Identification, reports of witness or suspected abuse/neglect/mistreatment/misappropriation of resident property should be reported immediately to the Supervisor on duty at the time of the incident. The Supervisor was to immediately notify the Administrator or Director of Nursing. The Social Services Director would also be notified. Under Investigation, Supervisory Staff and/or the Administrator would make all efforts possible to investigate and address concerns, grievances and reports of suspected abuse, neglect mistreatment, misappropriation of property and injuries. The initial report of the incident would be reported to the Office of the Inspector General (OIG) and Adult Protective Service (APS) within twenty-four (24) hours unless there was suspicion of a crime. If suspicion of a crime, the initial report of incident would be reported to the OIG, APS and local law enforcement within two (2) hour of the suspicion.

During the initial tour of the facility, on 10/29/12 at 12:45 PM, the daughter of Resident #2, stated last Tuesday, (10/23/12), she had reported to the nurse, Resident #2 had a gold wedding band and a gold ring with a diamond in the middle missing. She stated Resident #2 told her they took his/her rings off during a shower and did not replace them.

Review of Resident #2's medical record revealed the facility admitted the resident on 07/31/12 with diagnoses which included Parkinson's disease, History of Falls, Hypertension and Asthma. Review of the Admission Minimum Data Set (MDS) Assessment, dated 08/12/12, revealed the

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the OIG, Adult protective Services and the local Police Department within the 24 hour reporting requirement time. These items were unable to be found. The facility was unable to substantiate that the resident had these items or what happened to them. This same resident also reported she had cataract sunglasses missing. Upon Investigation, Social services contacted the eye doctor she had stated she got glasses from and they reported they had no record of her getting cataract glasses. The resident was seen by the Eye Doctor that comes to the facility on 11-16-12 and the facility will be replacing them. The Social Services Director for Unit 1 completed an updated inventory sheet for this resident on 11-2-12. The resident has been residing at this facility for approximately two years. On 11-19-12 the two Social Services Directors completed an audit over the last 60 days of all grievances and 24 reports and found no other potential allegations of misappropriation for any other resident.

**Systemic Changes**

The facility Administrator in-serviced the Social Services Directors on 10-30-12 on the facility Abuse Policy which included investigation of and reporting procedures of misappropriation to the OIG, Adult Protective Services and the local Police Department. The policy included reporting requirements within 24 hours to the above agencies along with immediate investigation protocols. The Social Services Directors were also in-serviced on a new Missing Item form that was

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facility had assessed Resident #2 with a Brief Interview of Mental Status (BIMS) of eight (8) out of fifteen (15), indicating the resident was moderately impaired in cognition.

Interview with the Social Service Director (SSD), on 10/29/12 at 1:10 PM, revealed she had been notified of the missing jewelry on 10/25/12. She stated she may have missed the morning meeting on 10/25/12. She stated, Resident #2 received showers on Wednesdays and during the weekend. The SSD stated she talked to the Certified Nursing Assistant (CNA), who gave Resident #2 a bath on Wednesday and she stated the ring was there the last time she gave Resident #2 his/her shower. She stated she had the nurse check the medication cart, did a room search and also search laundry and the shower room. The SSD stated the facility did not have this type of thing happen very often, she stated she did not know why she was notified of the missing rings, two days after they were reported missing and that she or someone probably should have notified the State Agency within twenty-four (24) hours.

Interview with the seven (7) to three (3) Charge Nurse, on 10/29/12 at 1:25PM, revealed she was not sure if Resident #2's daughter or who had told her of the missing rings on 10/23/12. She stated they searched for the rings and discussed them in shift report and placed the missing rings on the twenty-four (24) hour shift report. She stated they started a search on Tuesday. She stated she did not remember reporting the missing rings to the Director of Nursing (DON) or the SSD.

Interview with the DON, on 10/29/12 at 1:50 PM,

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implemented on 10-31-12 which includes the initial investigation of how to handle a missing item, including checking off where the staff member looked for items and reporting them immediately after initial search to the Administrator, Social Services Director and the Director of Nursing. All staff were re-in-serviced on facility Abuse Policy, reporting requirements, and new missing item form and facility Grievance Policy by the Administrator, Staff Development Director or Social Services Director on 10-30-12 through 11-9-12. Any staff member that was unable to attend any of the above in-services will not be able to work until they have completed it.

**Monitoring**

On 11-13-12, the Quality Assurance Committee met and discussed this deficient practice and approved the newly implemented Missing Item form along with facility's plan of correction for the future regarding the reporting of potential misappropriation of residents property along with in-services held for all Staff. The Social Services Director will be responsible for logging all Missing items on a Missing Items log. Any missing item forms filled out will be brought to the daily M-F Interdisciplinary Meeting for review. The Weekend House Supervisor will be responsible for notifying the Administrator, Social Services Director and the Director of Nursing on the weekends regarding any Missing Item Reports filled out. This log will be brought to the monthly Quality Assurance Committee for monitoring for 3 months or until compliance is achieved

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revealed they reviewed the shift report during the morning meeting. She stated they did discuss the missing rings. She also stated it was the SSD's responsibility to investigate.

Continued interview with the SSD, on 10/30/12 at 11:00 AM, revealed she had sent an e-mail to APS, SA and a detective with elder victim unit. She stated the reason she had not reported the missing rings was because she thought they would show up. She also said the facility had not had issues with missing valuables. The SSD stated she was aware of the regulations, but it was not solely her responsibility. She stated the facility did everything as a team approach.

Interview with the Administrator, on 10/30/12 at 11:45 AM, revealed she did not think the rings were stolen and no one expected it to be misappropriation of a resident's property.

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as determined by the Quality Assurance Committee.  
  
11-20-12