

Acceptable 03/08/15  
Compliance

PRINTED: 02/26/2015  
FORM APPROVED  
OMB NO. 0938-0391

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

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  02/12/2015
NAME OF PROVIDER OR SUPPLIER  SAYRE CHRISTIAN VILLAGE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3775 BELLEAU WOOD 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	INITIAL COMMENTS  A Recertification Survey was initiated on 02/10/15 and concluded on 02/12/15. Deficiencies were cited with the highest Scope and Severity of a "E".	F 000		02/18/2015	
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES  A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, resident council group interview, review of the facility's policy and procedures, review of the facility's follow-up resident and family concern/grievance form documentation and Resident Council Minutes, it was determined the facility failed to ensure attempts were made to resolve grievances for four (4) of twenty-two (22) sampled residents (Residents #6, #15, #16, and #18) and eight (8) unsampled residents (Unsampled Residents A,B,C, D, E, F, G, and H).  Review of the Resident Council Minutes, dated October, November, and December 2014, revealed the residents had complained, of their call bells not being answered timely and staff responding to their call lights, but turned the resident's light off without providing the requested care for all three (3) months. Interview with Residents #18 and Unsampled Residents A, D, E, F and G during the Group Interview and, also individual resident interviews revealed they	F 166	<b>F166 E RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</b>  <b>Targeted Residents</b> Resident #6, #15, #16, #18 and unsampled Residents A, B, C, D, E, F, G and H were affected by this allegation of non-compliance. A resident Council meeting was held on February 26, 2015. The Assistant Director of Nursing and Social Services Director attended meeting and explained to the council that the facility has updated its Resident Council Policy and its grievance policy to have increased checks in place to ensure grievances were followed up with timely. The Council members were also reminded that they could file a grievance at anytime and did not have to wait until resident council. Council was informed where to pick up forms if needed or that they could ask for Social Services, Unit Manager, etc. for the form and for assistance completing the form if needed. The Social Services Directors met with all residents above on February 27, 2015- March 3, 2015 to review the revised grievance policy and plan of correction for resolving grievances and call light audits that have been put into place.		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Cheryl Scoggin</i>			TITLE  Administration		(X6) DATE  3-18-15

Deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution has provided 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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continued to complain of their call bells being turned off before the care they needed was provided to them. However, review of the facility's documentation revealed no documented evidence the facility had attempted to resolve the residents' grievances regarding call lights.

In addition, the Resident Council Minutes for the past two (2) months revealed residents expressed concern regarding Units 1 and 2 being noisy at night. The facility provided inservices for staff regarding the residents' concerns; however, there was no documented evidence the facility audited or monitored to ensure the staff education was effective and the noise level had decreased at nights on the two (2) units. Therefore, Group Interview and individual resident interviews conducted during the survey revealed residents' still expressed the noise level at night as a concern, which affected Resident #18, and Unsamped Residents B and C.

The findings include:

Review of the facility's policy titled, "Resident Concern/Grievance", dated 08/19/11, revealed residents had the right to voice concerns with the expectation that "prompt efforts by the facility" would be made to resolve them. The Resident Council, any resident, family member or staff member might generate a Resident and/or Family Concern/Grievance Report in response to a concern or grievance. Continued review of the Policy revealed the Social Service Director (SSD) was designated for collecting, reviewing and communicating concerns or grievances to the Administrator within one (1) business day. Per the Policy, responses and results would be completed within five (5) business days.

F 166 Identification of other Residents

All residents have the potential to be affected. The Administrator in-serviced the Social Services Directors on February 27, 2015 regarding the facility's new Resident Council policy and grievance policy. The Administrator in-serviced all Department Directors on the revised Grievance Policy and Resident Council Policy on February 28, 2015.

**Systemic Changes**

The Director of Nursing has developed a call light audit and will be responsible for assigning call light audits to appropriate management staff including the Assistant Director of Nursing, Unit Managers, Restorative Nurse and Staffing Coordinator for monitoring. These audits will be done at least daily and will be done on random shifts and turned into the Director of Nursing for follow up for three months.

The Director of Nursing will be responsible for assigning different management staff including the Assistant Director of Nursing, Unit Managers, Restorative Nurse and Staffing Coordinator to come in unannounced 2-3 times weekly for 4 weeks, then weekly to check for noise levels at night. This will also be done for three months to ensure noise levels are acceptable.

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Additionally, concerns or grievances should be communicated in writing to the person(s) communicating the grievance/concern. The SSD would complete an investigation and confer with the Administrator regarding the findings, and the Administrator might or might not participate in the actual investigation. Further review of the Policy revealed the facility's concern report was to include the investigation findings, follow-up to the concern and Administrator's signature, and responses communicated within seventy-two (72) hours of completion of the investigation to the complainant.

1. Review of the facility's policy titled, "Answering the Call Light", undated, revealed it was the policy for staff to respond to the resident's requests and needs, and staff were to turn off the call light once they were ready to meet the resident's need. Per the Policy, staff were to leave the call light on if they had to leave to obtain help or supplies to meet the resident's need. Continued review of the policy revealed if staff were uncertain as to whether or not a resident's request could be fulfilled, or if they could not fulfill the resident's request, they were to ask the nurse supervisor for assistance. Further review of the Policy revealed if staff promised the resident they would return with an item or information, they were to do so promptly.

Review of the facility's Resident Council Minutes, dated 10/30/14, revealed the Ombudsman was present and informed the residents that "staff should meet their needs before call lights were turned off". Continued review revealed Residents #15 and #16, and Unsampled Resident B were in attendance at the Resident Council meeting.

F 166 The facility has implemented a new Grievance/Concern Program which will consist of the following components:

The Administrator has delegated the responsibility of grievance and/or complaint investigations to the social services department including resident council concerns, grievances, and complaints. The social services department may obtain assistance from the department that the grievance originated.

Upon receipt of a grievance and/or complaint, the social services department, with any assistance needed from other departments, will investigate the allegations and submit a written report within five (5) working days of receiving the grievance and/or complaint. The Administrator will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken.

The resident, resident council concerns, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings of the investigation and of the actions that will be taken to correct any identified problems. The person investigating will make such reports orally within (7) working days of the filing of the grievance or complaint with the facility.

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Review of the Resident Council Minutes, dated 11/20/14, revealed "the residents felt the call light response time was still an issue. Per the Minutes, Unsampld Resident D felt during the day on weekends staff getting call lights answered was slow, and Resident #14 felt there had been some improvement on the "7-3" shift, with no indication of AM or PM. Continued review of the Minutes revealed Resident #14 felt overall the response time needed to be better especially for those residents who required two (2) person assistance.

Review of the facility's Resident Council Minutes, dated 12/18/14, revealed "State Registered Nursing Assistants (SRNA's) were still" turning residents' call light off before care was given, "mostly when help was needed". Continued review revealed Residents #16 and #18, and Unsampld Residents B and C were in attendance at the meeting.

The facility provided no documented evidence the Ombudsman's concern, dated 10/30/14, regarding the call light response was addressed on a "Resident and Family Grievance" form.

Review of the facility's "Resident and Family Concern/Grievance", dated 11/21/14, revealed the concern/grievance was generated from the "Resident Council" meeting, and had been filed on behalf of the residents present in the meeting. Continued review of the "Resident and Family Concern/Grievance", dated 11/21/14, revealed call lights being answered had improved during the week, but not on the weekends which remained a problem. Per the "Resident and Family Concern/Grievance", dated 11/21/14, the action/response for the facility was for the

F 166 The social services director will conduct a follow-up with the resident including resident council members, concerning the resolution of the grievance in (7) to (10) days after an action plan was implemented to ensure corrective action was successful and grievance is resolved

Should the resident not be satisfied with the result of the investigation or if the grievance/ concern/complaint are not resolved, a new grievance will be initiated by the social services department and a new action plan for resolution will be implemented.

In addition, all resident concerns/grievances will be discussed in the daily Continuous Quality Improvement (CQI) meetings.

On March 4, 2015- March 7, 2015 all staff were in-serviced on the new Grievance Program, Call light timeliness, and noise level at night by the Director of Nursing and Assistant Director of Nursing.

**Monitoring**

The Director of Nursing will be responsible for tracking daily call light audits and weekly noise level audits. These audits will be brought to the monthly Quality Assurance Performance Improvement (QAPI) meeting for the next three months for review and revision as indicated.

In addition all resident concerns/grievances will be discussed in the daily CQI meetings and the grievance logs, resident council minutes and

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Weekend House Supervisor to re-inservice staff on call lights for weekend staff going over the importance of answering residents' call lights in a timely manner. Review of the facility's "Statement of In-service training for Employees", dated 11/26/14 through 11/29/14, revealed staff were inserviced as indicated; however, there was no documented evidence the call lights on the units were being monitored or audited.

Review of the "Resident and Family Concern/Grievance" dated 12/19/14, revealed the concern/grievance came from the "Resident Council" meeting, and the concern was filed on the behalf of "all residents". Per the "Resident and Family Concern/Grievance", dated 12/29/14, the nature of the grievance revealed the SRNAs were still turning lights off before requested care was given. The SSD followed up with Resident #17 and Unsampled Resident A, who reported their call lights were being answered better. However, there was no documented evidence the SSD followed up with other residents who had participated in the Resident Council meeting to determine if their call light response had also improved. Further review of the "Resident and Family Concern/Grievance" dated 12/19/14, revealed the action/response was that staff were again inserviced on not turning light off before care was given. Review of the inservices revealed staff were inserviced on the call lights again on 12/19/14 which extended to January and February due to the holidays. However, the facility provided no documented evidence call lights were being monitored or audited to ensure the in-services were effective.

Interview with residents during the Group  
Interview conducted on 02/10/15 at 3:45 PM by

F 166 action plans will be submitted to the monthly Quality Assurance Performance Improvement (QAPI) meetings to oversee that grievances have been resolved. The Quality Assurance Performance Improvement Committee consists of the Medical Director, the Administrator, the Director of Nursing, the Social Services Director, the MDS Coordinator, the Dietary Manager, the Maintenance Director, the Assistant Director of Nursing, the Medical Records Clerk, the Restorative Nurse, the Pharmacist and the Business Office Manager.

3-8-2015

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the State Survey Agency Surveyor, revealed Resident #18, Unsampld Resident A, Unsampld Resident D, Unsampld Resident E, Unsampld Resident F, Unsampld Resident G, and Unsampld Resident H, were all present in the meeting. All the residents present in the Group Interview stated staff continued to turn off their call lights when care was needed, before providing the care. The residents reported staff told them they would return after turning off the call light, but many times it would take them awhile before they returned, and sometimes they never returned. Unsampld Resident D stated Administration was aware of their concerns; however, the resident did not feel as though their concerns were addressed, as the residents were told by staff that they would look into their concerns, but it continued "to happen".

Review of Resident #15's record revealed the resident had diagnoses which included history of a Stroke, Constipation and Anxiety. Review of the Quarterly Minimum Data Set (MDS) revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of twelve (12) which indicated he/she was moderately cognitively impaired and interviewable. Continued review of the MDS revealed the facility assessed Resident #15 to require extensive assistance of two (2) staff for toileting.

Interview with Resident #15, on 02/12/15 at 2:30 PM, revealed he/she had to wait over thirty (30) minutes or longer before staff assisted him/her with care when requested. Resident #15 reported staff would respond to his/her call light, turn it off, leave the room, without attending to his/her needs. Per interview, this was addressed

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F 166	<p>Continued From page 6</p> <p>in Resident Council before, but nothing had been done about it. Resident #15 reported that by the time staff finally responded to him/her, he/she had already been incontinent. Per Resident #15, weekends and holidays were the worst times. According to Resident #15, he/she had a stroke and had problems with his/her bladder. Resident #15 stated he/she was unable to transfer to the toilet without assistance and, thus "wet" himself/herself waiting on staff. Further interview revealed when this happened it made him/her feel like a "dog".</p> <p>Interview with the Ombudsman, on 02/12/15 at 12:55 PM, revealed she observed staff go into residents rooms, cut the call light off without meeting the needs of the residents. She reported this was a concern of the residents, which was why she told the residents at the 10/30/14 Resident Council meeting staff should be answering their call lights. Continued interview with the Ombudsman revealed she observed staff respond to Resident #15's call light by turning the light off without providing the requested care to the resident. She reported Resident #15 expressed concerns about staff doing this at the facility's Resident Council meetings.</p> <p>Interview with SRNA #1, on 02/12/15 at 3:48 PM, revealed staff had been in-serviced on call lights before, and she stated staff should respond to the call lights immediately. Per interview, staff should leave the resident's call light on, get assistance if needed, and then turn the call light off once they were providing care for the resident. Continued interview revealed if she forgot and turned a call light off, she would turn the resident's light back on, so as not to forget about the resident. SRNA #1 reported Resident #15 was both continent and</p>	F 166		

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F 166	<p>Continued From page 7</p> <p>incontinent of bowel and bladder at times, and added the resident might "dribble" sometimes. She stated Resident #15 was incontinent mostly at night, and tried to go to the bathroom during the day. SRNA #1 stated Resident #15 had complained to her in the past about waiting for staff to respond to his/her call light when having to go to the bathroom. Continued interview with SRNA #1 revealed resident's did not express to her a concern regarding the noise level.</p> <p>Review of Unsampld Resident B's record revealed diagnoses which included Kidney Injury, Urinary Tract Infection and Diabetes. Review of the Quarterly MDS, dated 01/02/15, revealed the facility assessed the resident to have a BIMS score of twelve (12) which indicated moderate cognitive impairment and the resident was interviewable. Continued review of the MDS revealed Unsampld Resident B required extensive assistance of two (2) staff for his/her ADLs. Continued review of the MDS revealed the resident was occasionally incontinent of bowel and bladder.</p> <p>Interview with Unsampld Resident B, on 02/12/15 at 6:05 PM, revealed it was a slow response for staff answering his/her call light. Unsampld Resident B stated he/she had experienced a bowel movement while waiting on staff to respond to his/her call light, and then staff had to clean him/her up which made him/her "mad", and he/she didn't like it when that happened. According to Unsampld Resident B, staff should take care of what he/she needed before they turned the light off. Per Unsampld Resident B, staff often turned his/her call light off when they responded to his/her call light and tell him/her they would return; however, many times</p>	F 166		

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F 166	Continued From page 8 they were slow to return or they never returned. Unsampld Resident B reported the problem mostly occurred in the late afternoon and he/she had to wait longer than twenty (20) minutes before for someone to assist him/her care.  Record Review revealed Resident #6 had diagnoses which included Urinary Tract Infection, Diabetes Mellitus, Depression, Chronic Kidney Disease Stage III, Debility and Muscle Weakness. Review of the Quarterly MDS dated 11/28/14, revealed the facility assessed Resident #6 to have a BIMS score of fifteen (15) which indicated he/she was cognitively intact and interviewable.  Interview, on 02/12/15 at 3:00 PM, with Resident #6 revealed he/she had not attended resident counsel in three (3) to four (4) months; however, when he/she last attended Resident Counsel he/she did recall concerns had been voiced by the residents regarding call light response times by staff. Resident #6 revealed he/she did not recall if any staff member followed up with him/her individually regarding the concerns he/she voiced in the Resident Council meeting regarding call light response times by staff. Continued interview revealed it could take ten (10) to fifteen (15) minutes at times for call lights to be answered. Per interview, he/she had experienced staff turning off call lights before providing care and then not returning for ten (10) to fifteen (15) minutes to provide the care.  Record Review revealed Resident #16 had diagnoses which included Urinary Tract Infection, Arthritis, Osteoporosis, Parkinson' Disease, Depression and Constipation. Review of the Significant Change MDS dated 12/23/14 revealed the facility assessed Resident #16 to have a	F 166		

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BIMS score of nine (9) which indicated he/she had moderate cognitive impairment and was interviewable.

Interview with Resident #16 revealed he/she had attended all monthly resident counsel meetings and the residents had voiced concerns regarding call lights not being answered as quickly as they should be in those meetings for the past several months. Continued interview revealed it sometimes could take up to thirty (30) to forty (40) minutes for call bells to be answered, and he/she had an issue with staff turning off the call light. Resident #16 stated staff would tell him/her they would get the staff assigned to him/her and the assigned staff would not return to assist for thirty (30) to forty (40) minutes. Per interview, the extended call light response times had not happened frequently, but had occurred before. Resident #16 further reported no one had ever followed up with him/her individually after the Resident Council meetings regarding his/her concerns about the call light issue. Resident #16 revealed staff had asked all residents about call light concerns on response times in the next Resident Council meeting, and the residents continued to voice concerns about this.

Interview with SRNA #2, on 02/12/15 at 2:44 PM, revealed she would cut the call light off before providing care to the resident, but would always report back to the resident. SRNA #2 stated it was possible for a SRNA to forget about returning back to a resident when cutting off the residents call light.

Interview with SRNA #3, on 02/12/15 at 6:15 PM, revealed she had turned the call light off before providing care to the residents before. She

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NAME OF PROVIDER OR SUPPLIER  SAYRE CHRISTIAN VILLAGE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3775 BELLEAU WOOD DRIVE LEXINGTON, KY 40517	

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F 166	Continued From page 10 stated she would go get someone to assist her with the resident, then return back to the resident. SRNA #3 revealed it was possible to "forget" about a resident when turning the light off before providing care, especially when the SRNAs were busy.  Interview with SRNA #4, on 02/12/15 at 6:45 PM, revealed she normally turned the call light off before providing care to the resident and went to find someone to assist her with the resident's care. She reported she would do this before allowing the call light to continue to go off for extended periods of time.  Interview with Licensed Practical Nurse (LPN) #3, on 02/12/15 at 6:30 PM, revealed she tried to monitor the call lights and, she could not say for certain staff were following the facility's protocol, but they should have been. She stated the SRNAs should leave residents' call lights on when they went to get someone to assist with the resident's care.  Interview with the Unit 2 Coordinator, on 01/12/15 at 6:25 PM, revealed she was not aware of any issues related to call light response times since she started her employment at the facility in November of 2014. Per interview, she had not been completing any formal audits of call light response times, but did try to keep a watch on call lights for her unit. She reported each SRNA, medication cart nurse, Charge Nurse and Unit Coordinator had beepers for call lights. She revealed the call light initially went to the SRNA beeper, then after the call light sounded for five (5) minutes it then sounded on the medication cart nurse's beeper. The Unit 2 Coordinator stated if the call light continued to go off, after ten	F 166		

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F 166	<p>Continued From page 11</p> <p>(10) minutes it sounded to the Charge Nurse's beeper and finally, after fifteen (15) minutes if it wasn't answered it sounded to the Unit Coordinator's beeper. Per the Unit 2 Coordinator, she was not aware of staff turning off call lights before providing care, but her expectation would be for care to be provided prior to the call light being turned off. She revealed her expectation would be for call light response times to be as quick as possible and preferably to be answered within ten (10) minutes. Further interview revealed she did recall being inserviced on call lights in January 2015, and the process for a resident having a grievance would be for the staff to complete a grievance form and give the form to the Social Services Department to follow up on.</p> <p>Interview with the Social Service Director (SSD), on 02/12/15 at 11:44 AM and 7:21 PM, revealed if a grievance was made on the behalf of a resident, a grievance form would be filled out. The SSD revealed if a grievance was expressed in Resident Council meetings, and the group shared the same concerns, then a grievance form would be filed on behalf of all the residents. In regards to the concerns related to the call light she reported those concerns were sent to the nursing department, who looked into educating the staff. The SSD stated a grievance form was not filled out regarding the October Resident Council meeting as the residents had no concerns, and because the Ombudsman was present and addressing concerns she had heard about with the residents. Continued interview revealed the Ombudsman informed the residents at that meeting staff should attend to their needs before turning off their call lights. The SSD reported she followed up with Resident #17 and Unsamped Resident A regarding the call lights</p>	F 166		

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F 166	Continued From page 12 and they reported no concerns. She stated however, she did not interview all of the resident's in the Resident Council meeting to determine if the staff in-services had been effective. The SSD stated the residents' concerns should have been brought before the facility's Quality Assurance (QA) Committee where they would use a Quality Assurance Performance Improvement (QAPI) tool to monitor/audit the effectiveness of the call lights being answered. Per the SSD, however, this had not occurred.  Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), on 02/12/15 at 4:45 PM, revealed it was their expectation for the SRNAs to be in the resident's room providing care before they turned the call light off. Continued interview with the DON and ADON revealed this was important so staff would meet the needs of the residents as per the facility's policy. The ADON revealed she provided the in-services to staff regarding the answering of the call lights, and she thought the in-services were effective because she was told by the SSD, who had followed up with the residents, there were no longer any concerns regarding call light issues. The ADON and DON stated they had not audited or monitored the call lights; however, the residents' grievance should have been brought to the facility's QA Committee so the concerns could have gone through the auditing and monitoring process.  2. Continued review of the 11/20/14 Resident Council Minutes revealed the residents had complaints of the noise level in the hallways still being an issue with staff "slamming doors and yelling from one end of the hall to another". Review revealed Resident #6, Resident #15,	F 166		
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F 166	<p>Continued From page 13 Resident #16, Resident #18, and Unsampld Resident B were in attendance.</p> <p>Continued review of the facility's Resident and Family Concern/Grievance, dated 11/21/14, revealed the noise level on unit 1 had improved, but unit 2 was still too loud. Review revealed the action to be taken was to re-inservice staff about the noise level and a sign was to be put on unit 2 behind the nurse's station to remind staff this was the residents' home environment.</p> <p>Continued review of the "Statement of In-service training for Employees", dated 11/26/14 through 11/29/14, revealed staff were inserviced on the issue, however, there was no documented evidence the noise level on the units was being monitored or audited.</p> <p>The Group Interview conducted on 02/10/15 at 3:45 PM, revealed Resident #18, Unsampld Resident A, Unsampld Resident D, Unsampld Resident E, Unsampld Resident F, Unsampld Resident G, and Unsampld Resident H, were all present in the meeting. Continued interview with the residents present during the meeting revealed staff were still being noisy at night, talking loudly and moving carts up and down the hallways.</p> <p>Record review revealed Resident #18 had diagnoses which included Failure to Thrive, Anxiety and a history of falls. Review of the annual Minimum Data Set, dated 01/16/15, revealed Brief Interview Mental Status (BIMS) 12 and was cognitively intact and interviewable.</p> <p>Interview, on 02/12/15 at 4:50 PM, with Resident #18 revealed he/she was awakened after 11:00 PM during the week by staff making noises in the</p>	F 166		

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F 166	Continued From page 14 hallway. Resident #18 stated he/she had expressed concern to staff about this; however, the situation had not improved. Per interview, on weekend nights staff were quiet.  Continued interview with Unsampled Resident B, on 02/12/15 at 6:05 PM, revealed the noise level continued to be "loud" at night. Per interview, he/she told staff that SRNA #5 was noisy at night, often yelling from one end of the hallway to the next, and this interrupted his/her sleep.  Interview with Unsampled Resident C on 02/12/15 at 2:40 PM, revealed there was too much noise in the hallways, and staff often talked, hollered, and laughed at each other in the hallways at night. Per interview, he/she had not seen much change since the incident was brought up in Resident Council, and stated he/she didn't "feel good about it". Unsampled Resident C stated staff did not need to be making noise like that, especially at night.  Continued interview with Resident #16 revealed he/she had no concerns with noise levels in the hallways, but did remember other residents voicing concerns about noise levels in the hallways during Resident Council.  Interview with SRNA #5, on 02/12/15 at 6:40 AM, revealed she was inserviced on the noise level at night. She stated she was told to keep the noise down because the residents needed to sleep. Per interview, she was in-serviced on this again last week. SRNA #5 reported the residents had not expressed to concerns to her regarding the noise level at night.  Continued interview with LPN #3, on 02/12/15 at	F 166		

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F 166 Continued From page 15  
6:30 PM, revealed she was aware Unsampled Resident B expressed concerns about SRNA #5 being loud in the hallways, but thought "that was taken care of" and the issue had been resolved.

Continued interview with the Unit 2 Coordinator, on 01/12/15 at 6:25 PM, revealed she did recall being inserviced on noise levels in hallways in January of 2015. She stated she did recall someone mentioning a complaint about noise levels in hallways on the 3:00 PM through 7:00 AM shifts.

Continued interview with the SSD, on 02/12/15 at 11:44 AM and 7:21 PM, revealed in regards to the concerns related to the noise level, she reported the concerns were sent to nursing, who looked into educating the staff. The SSD reported she was unaware of SRNA #5 being loud at night and stated staff should have told her. The SSD stated the concerns regarding the noise level should also have been brought before the QA Committee where a QAPI tool would be used to monitor/audit the effectiveness of the noise level in the hallways.

Continued interview with the DON and ADON, on 02/12/15 at 4:45 PM, revealed the ADON performed the staff in-services to staff regarding the the noise level in the hallways. The ADON revealed she thought the in-services were effective because she was told by the SSD the residents no longer had any concerns regarding the noise level. Per interview, they had not audited or monitored the noise level in the hallways; however, this issue should have also been taken to the QA Committed so auditing and monitoring could have been implemented.

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F 166 Continued From page 16  
Interview with the Administrator, on 02/12/15 at 8:00 PM, revealed it was her expectation the concerns brought up in Resident Council meeting would be monitored and audited to ensure the action taken was effective. The Administrator stated she would also expect the SSD to follow-up with the resident members of the Resident Council who expressed concerns related to their grievances/concerns.

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  
SS=D

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review, review of the Resident Council Meeting minutes and review of the facility's policy, it was determined the facility failed to promote care for residents in a manner to maintain or enhance each resident's dignity for one (1) of fifteen (15) sampled residents (Resident #15), and one (1) of eight (8) unsampled residents (Unsampled Resident B). Resident #15 and Unsampled Resident B expressed they experienced bowel incontinence on several occasions while waiting for staff to respond to their call lights for over thirty (30) minutes. The residents expressed being incontinent made them "mad" and feel like they were being treated like a "dog".

The findings include:

F 166  
  
F 241 F241 D DIGNITY AND RESPECT OF INDIVIDUALITY

**Targeted Residents**  
Resident #15 and Unsampled Resident B were both placed on a Bowel and Bladder Diary on February 27, 2015 to March 5, 2015 in effort to obtain a better understanding of their bowel and bladder patterns. With this information, both residents toileting schedule has been updated to prevent avoidable bowel and bladder incontinence. The Unit Manager will follow up with these two residents weekly to ensure they are being treated with dignity.

**Identification of other Residents**  
All residents that need assistance with toileting have the potential to be affected. No other grievances/concerns were found by any other residents.

**Systemic Changes**  
The Assistant Director of Nursing assigned and in-serviced several staff members on March 3, 2015 to do Daily Quality

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F 241	<p>Continued From page 17</p> <p>Review of the untitled and undated facility document provided revealed every resident in a long-term care facility should have the right to be treated with consideration, respect and full recognition of his/her dignity and individuality.</p> <p>Review of the facility's policy titled, "Answering the Call Light", undated, revealed it was the policy for staff to respond to the resident's requests and needs, and not turn off the call light until they were ready to meet the resident's need.</p> <p>Continued review of the Policy revealed if staff felt they could not meet residents' needs they were to ask the Nurse Supervisor for help.</p> <p>Review of the facility's Resident Council Minutes, dated 10/30/14, revealed the Ombudsman informed residents present, who included, Resident #15 and Unsampld Resident B, that "staff should meet their needs before call lights were turned off". Review of the Resident Council Minutes, dated 11/20/14, revealed the residents present, who included Resident #15 and Unsampld Resident B, felt staff's call light response was still an issue. Review of the facility's Resident Council Minutes, dated 12/18/14, revealed Unsampld Resident B was in attendance at the meeting, and the residents present continued to express concerns regarding the "State Registered Nursing Assistants (SRNA's) still turning call lights off before care was provided.</p> <p>1. Review of Resident #15's record revealed the facility admitted him/her on 06/23/10 with diagnoses which included, Anxiety, history of Stroke and Constipation. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 12/05/14, revealed the facility assessed the</p>	F 241	<p>Assurance Performance Improvement (QAPI) rounds Monday - Friday. The House Supervisor will be responsible for completing these rounds on Saturday, Sunday and Holidays. These rounds will be turned into the Assistant Director of Nursing and will be reviewed daily Monday - Friday in the facility daily Continuous Quality Improvement (CQI) meeting. Theses rounds will help ensure that all residents are being treated with dignity and respect as it relates to his or her full recognition of individuality.</p> <p>The Social Services department will be responsible for completing random resident interviews weekly regarding staff care and treatment. The results from these surveys will be reported to the monthly Quality Assurance Performance Improvement (QAPI) Meeting.</p> <p>The Director of Nursing has developed a call light audit and will be responsible for assigning call light audits to appropriate management staff including the Assistant Director of Nursing, Unit Managers, Restorative Nurse and Staffing Coordinator for monitoring. These audits will be done at least daily and will be done on random shifts and turned into the Director of Nursing for follow up.</p> <p>On March 4, 2015 - March 7, 2015 all staff was in-serviced by the Director of Nursing and Assistant Director of Nursing on dignity</p>	

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F 241	<p>Continued From page 18</p> <p>resident to have a Brief Interview for Mental Status (BIMS) score of twelve (12) which was indicative of him/her being moderately cognitively impaired, but interviewable. Continued review of the MDS revealed the facility assessed Resident #15 to be frequently incontinent of bladder and always continent of bowels, and to require extensive assistance of two (2) staff for toileting. Review of Resident #15's three (3) day bowel and bladder diary dated 12/05/14, for the Quarterly MDS Assessment, revealed the resident continued to be continent of bowel and incontinent of bladder. Continued review revealed staff were to continue the toileting schedule for Resident #15 upon arising, before and after meals, at night and as needed.</p> <p>Review of Resident #15's Comprehensive Care Plan, dated 06/17/11, revealed the facility had care planned the resident for altered elimination regarding "occasional" bowel incontinence, with a goal to decrease the risk for complications of incontinence. Continued review of the care plan revealed interventions which included scheduled toileting upon arising, before and after meals, at bedtime and as needed.</p> <p>Interview, on 02/12/15 at 2:30 PM, with Resident #15, revealed the resident reported having to wait over thirty (30) minutes or longer before staff assisted him/her with care at times. Per interview, staff would come to his/her room in response to the call light, turn the call light off and leave the room without assisting him/her with his/her need. According to Resident #15, he/she had reported and discussed this in Resident Council, but nothing had been done about it. Resident #15 reported he/she had a stroke in the past and had problems with his/her bladder and</p>	F 241	<p>and respect of residents and their individuality. All staff was also in-serviced on call light policy and timeliness of response to call lights.</p> <p><b>Monitoring</b> The Assistant Director of Nursing will be responsible for tracking daily Quality Assurance Process Improvement (QAPI) rounds and the Director of Nursing will be responsible for tracking daily call light audits.</p> <p>Results of the rounds and audits will be submitted to the monthly QAPI Committee for review and revision until the QAPI committee has determined 100% compliance has been achieved.</p> <p>3-8-2015</p>

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was unable to transfer him/herself to the bathroom. Per Resident #15, many times by the time staff responded to help, he/she had been incontinent and soiled, with the weekends and holidays being the worst. Further interview revealed when he/she had become wet waiting on staff it made him/her feel like a "dog".

Interview, 02/12/15 at 12:55 PM, with the Ombudsman revealed she had observed staff answering residents' call lights and turning them off without assisting the resident with his/her need. Per interview, as this was a concern of residents, she had discussed the resident's concerns and rights with them in the 10/30/14 Resident Council Meeting. She stated Resident #15 had expressed concerns regarding this issue at the facility's Resident Council Meeting before. Further interview revealed she had also observed staff answer Resident #15's call light and turn it off without providing the care the resident required.

Interview, on 02/12/15 at 3:48 PM, with SRNA #1, revealed Resident #15 was mostly incontinent at night; however, during the day he/she tried to go to the bathroom. She stated Resident #15 continant and incontinent of bowel and bladder and might "dribble" at times. Per interview, Resident #15 had complained of having to wait for staff to answer his/her call light when having to go to the bathroom. She stated staff should respond to residents' call lights immediately, and leave the light on until able to provide the care required.

2. Review of Unsampled Resident B's record revealed the facility admitted the resident on 10/09/12 with diagnoses which included,

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NAME OF PROVIDER OR SUPPLIER  SAYRE CHRISTIAN VILLAGE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3775 BELLEAU WOOD 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 241	<p>Continued From page 20</p> <p>Diabetes, Kidney Injury and history of Urinary Tract Infection (UTIs). Review of Unsampled Resident B's Quarterly MDS, dated 01/02/15, revealed the facility assessed him/her to have BIMS score of twelve (12) which indicated moderate cognitive impairment, and the resident was interviewable. Continued review of the MDS revealed the facility assessed the resident as requiring extensive assistance of two (2) staff, and to be occasionally incontinent of bowel and bladder. Review of Unsampled Resident B's three (3) day bowel and bladder diary dated 01/02/15, for the Quarterly MDS Assessment, revealed the resident was occasionally incontinent of bowel and frequently incontinent of bladder.</p> <p>Review of Unsampled Resident B's Comprehensive Care Plan, dated 10/22/12, revealed the facility care planned the resident for altered elimination in regards to being frequently to totally incontinent of bladder, with a goal for the resident to have decreased risk for complications of incontinence. Continued review revealed the interventions included providing the resident with scheduled toileting.</p> <p>Interview, on 02/12/15 at 6:05 PM, with Unsampled Resident B revealed staff were slow to respond to his/her call light, and reported having experienced bowel incontinence while waiting for staff. Per interview, staff often turned his/her call light off and tell him/her they would return; however, were slow to return or never returned. Unsampled Resident B stated the staff should take care of his/her need before they turned the call light off. According to Unsampled Resident B, the problem mostly occurred late afternoon and at times he/she had to wait longer</p>	F 241	

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			(X5) COMPLETION DATE

**F 241** Continued From page 21  
than twenty (20) minutes before someone assisted him/her with his/her care. Further interview revealed when he/she had to have staff clean him/her up it mad the resident "mad". Unsampld Resident B stated he/she didn't like it.

Interview, on 02/12/15 at 2:44 PM, with SRNA #2, revealed she had turned residents' call lights off before providing care to the resident. She stated she always reported back to the resident however. Per interview, it was possible a SRNA could forget to return to a resident though if they turned the call light off.

Interview, on 02/12/15 at 6:15 PM, with SRNA #3, revealed she turned the call light off before providing care to the residents, go get someone to assist and return to the resident's room to provide care. Per interview, SRNAs could possibly "forget" to return to a resident if they turned the call light off before providing care, especially when they were busy.

Interview, on 02/12/15 at 4:45 PM, with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), revealed it was expected SRNAs would be in residents' room providing care before their call light was turned off. Continued interview with the DON and ADON revealed this was important so that staff would meet the needs of the residents, as per the facility's policy.

**F 241**

**F 323** 483.25(h) FREE OF ACCIDENT  
**SS=D** HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives

**F 323** **F323 D Free of Accidents**  
**Hazards/Supervision/Devices**

**Targeted Residents**  
No residents were affected by this alleged deficient practice. On 2-10-15 after finding a closet unlocked, it was locked and later that day

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F 323 Continued From page 22  
adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview and review of the facility's Manufacturer Safety Data Sheets, it was determined the facility failed to ensure the environment was as free from accident hazards as possible for facility residents. Tour observation of Unit Two revealed an unlocked janitor supply closet, in the hallway, with a sign on the door: "Danger- Chemical Storage", with hazardous chemicals accessible to residents.

The findings include:

Interview, on 02/12/15 at 7:51 PM, with the Administrator revealed the facility had no hazardous chemical storage policy, but her expectation was chemical hazards were stored in areas which were inaccessible to residents.

Observation of a hallway on Unit Two with the Minimum Data Set Coordinator (MDS)/Licensed Practical Nurse (LPN) #1, on 02/10/15 at 11:15 AM, revealed a janitor supply closet, with a sign "Danger - Chemical Storage", which opened when the knob was turned. Observation, of the closet revealed the room contained sani wipes, handsanitizer, floor cleaners, and other cleaning products.

Interview, on 02/10/15 at 11:15 AM, with MDS/LPN #1 revealed the supply closet contained chemicals and the door was supposed

F 323 all chemicals from the closet were removed and placed in the laundry area which is not located on a resident unit. Maintenance immediately checked all other closets to ensure they were locked and areas were free from Hazards. All staff was in-serviced by the Housekeeping Supervisor on Hazards and the importance of keeping them away from residents and ensuring storage closets are locked on February 10 thru February 14, 2015.

**Identification of other residents**  
All residents that are confused and wander potentially could be affected by this alleged deficient practice.

**Systemic changes**  
All Chemicals have been moved by Housekeeping and will remain behind at least two locked doors for added protection. The Life Safety Team met on February 27, 2015 and reviewed F Tag 323. The Life Safety team has added extra checks on each shift to help ensure the facility remains free from potential hazards. The housekeepers will be responsible for checking that all doors are locked Sunday - Saturday on day shift. The Assistant Maintenance Director will check doors on second shift when performing his rounds; the 3<sup>rd</sup> shift desk attendant will be responsible for checking for unlocked doors and hazard on night shift. The weekend House Supervisor will be responsible for checks on the weekends. The Life Safety Team will perform weekly Safety Rounds for three months to help identify any potential hazards. The Life Safety Team consists of the Maintenance Director,

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F 323	<p>Continued From page 23</p> <p>to be locked. She stated the door was usually locked and was unsure why it was unlocked.</p> <p>Closer observation, on 02/10/15 at 12:10 PM, of the chemical containers, in the supply closet revealed: nine (9) plastic containers of Husky Uric Acid Eradicator, two (2) plastic containers of Virex II 256 One Step Disinfectant Cleaner and Deodorant with a hazardous warning label which noted first aide should be provided if in eyes, on skin, and if swallowed call poison control; one (1) plastic container of Stride HC Neutral Cleaner which had a hazardous warning label which read causes eye irritation; one (1) plastic container of Glance NA Glass and Multipurpose Cleaner with a warning label which read avoid contact with skin and eyes; four (4) plastic one (1) gallon containers of Sunny Side Floor Coating and Finishing Material; two (2) plastic bottles of Citrus Scrub N Shine, and five (5) plastic bottles of 40.5 ounces of hand sanitizers.</p> <p>Review of the facility's Material Safety Data Sheets (MSDS) under Hazardous Identification: The MSDS for Husky Uric Acid Eradicator, prepared date 02/15/12, revealed may cause skin or eye irritation and if swallowed may cause irritation of the mucosal linings of the mouth, throat, esophagus or stomach. The MSDS for Virex II 256 One -Step Disinfectant Cleaner and Deodorant, prepared date 06/22/06, revealed Emergency Overview: "Danger. Corrosive. Causes skin and eye burns, harmful or fatal if swallowed". The MSDS for Stride HC Neutral Cleaner, prepared date 06/11/14, revealed causes severe eye irritation and if ingested may cause irritation to mouth, throat and stomach. The MSDS sheet for Glance NA Glass and Multipurpose Cleaner, prepared date 04/01/11,</p>	F 323	<p>Administrator, Social Services Director, Central Supply Clerk, Housekeeping Supervisor, Dietary Director, Human Resource Generalist and the Activities</p> <p>An all staff in-service was held March 4-7, 2015 on Accidents and Hazards given by the Assistant Director of Nursing and the Director of Nursing.</p> <p><b>Monitoring</b></p> <p>Results from the safety rounds and door checks will be taken to the Quality Assurance Performance Improvement (QAPI) Committee for three months for review and revision as indicated.</p>	3-8-2015

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F 323	<p>Continued From page 24</p> <p>revealed under Hazard Identification Emergency Overview: "Caution". May be mildly irritating to eyes and skin. The MSDS for Sunny-Side Floor Coating and Finishing Material, undated, revealed causes mild eye and skin irritation, and if swallowed symptoms may include nausea, vomiting, pain and diarrhea. The MSDS for Citrus Scrub N Shine, undated, revealed severely corrosive to the skin and eyes causes severe burns and if ingested may cause burns to the mouth, throat, and stomach. The MSDS for Purell Instant Hand Sanitizer, date 03/24/11, revealed may cause eye irritation and upset stomach.</p> <p>Further interview, on 02/10/15 at 12:21 PM, with MDS/LPN #1 revealed they had no residents who wandered into other rooms on the open units, to include Unit Two, but had some residents, who ambulated or used wheelchairs who were assessed as not cognitively intact.</p> <p>Interview, on 02/11/15 at 3:04 PM, with Housekeepers #1, #2, and #3 revealed they worked on Unit Two and went in and out of the supply closet to get supplies. They revealed the door had a lock keypad to open; however, there was a latch on the inside closet door, which easily turned, and allowed the door to be unlocked. They further revealed they never checked to see if the door was open after exiting and always used the keypad when they entered. The Housekeepers revealed there were dangerous chemicals in the closet that were harmful if swallowed or got into a resident's eyes.</p> <p>Interview, on 02/12/15 at 2:54 PM, with the Housekeeping/Laundry Supervisor revealed the janitor supply closet was not supposed to be open</p>	F 323	

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NAME OF PROVIDER OR SUPPLIER  SAYRE CHRISTIAN VILLAGE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3775 BELLEAU WOOD DRIVE LEXINGTON, KY 40517
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F 323 Continued From page 25

and she made rounds to check doors but staff was not checking to see if it was locked after use and used the punch code when they entered. She revealed it was the first time someone reported it had been open and they had discussed the incident and felt the latch was accidentally bumped by staff. She further revealed it was a concern if residents had access to the products because some of the chemicals were eye irritants and some required medical attention if swallowed; however, some of the containers required a sharp object like a knife to open.

Interview, on 02/12/15 at 4:06 PM, with Maintenance Staff revealed when he made rounds he did not check to see if keypad doors were locked. He revealed it was possible the latch, to unlock the door, was accidentally bumped by staff and the door was unlocked. He further revealed there were chemical products in the closet, like Virex, in sealed containers.

Interview, on 02/10/15 at 11:58 AM, with the Director of Nursing (DON) revealed the janitor supply closet was typically locked and thought the inside latch was accidentally switched to open position by staff coming out of the closet. The DON revealed the closet had hazardous chemicals.

Interview, on 02/12/15 at 7:51 PM, with the Administrator revealed she felt it was an isolated incident and had no negative outcome from any resident gaining access to a hazardous chemical. The Administrator further revealed the facility had a locked dementia unit and had no wandering residents off the dementia unit. The Administrator stated environmental safety rounds were done monthly and maintenance did rounds

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F 323	Continued From page 26 and checked doors.	F 323			

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K 000 INITIAL COMMENTS

K 000

CFR: 42 CFR 483.70(a)  
Building: 02  
Plan Approval: 3/14/2011  
Survey under: NFPA 101 (2000 Edition), Chapter 18 (new health care)  
Facility type: SNF/NF  
Type Of Structure: Two (2) stories Type II (111) Unprotected  
Smoke Compartment: Two (2)  
Fire Alarm: Complete fire alarm (new installation)  
Sprinkler System: Complete automatic sprinkler system (new installation)  
Generator: Type II, Diesel (new installation)

A Standard Life Safety Code Survey was initiated and concluded on 02/11/15. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility (New Edition) was found to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred thirty (130) beds and the census was one hundred twenty three (123) the day of the survey.

03 18 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Chris Scosin*  
ADMINISTRATOR  
TITLE  
3/18/15  
(X6) DATE

A 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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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 Type Of Structure: One (1) story Type V (111) Protected Smoke Compartment: 5 Fire Alarm: Complete fire alarm Sprinkler System: Complete automatic sprinkler system  A Standard Life Safety Code Survey was initiated and concluded on 02/11/15. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred thirty (130) beds and the census was one hundred twenty three (123) the day of the survey.  Deficiencies were cited with the highest Scope and Severity of an "D".	K 000		2/18/2015	
K 147	NFPA 101 LIFE SAFETY CODE STANDARD	K 147	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.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[Signature]*

TITLE  
*Administrator*

(X6) DATE  
3-18-15

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution has provided sufficient safeguards 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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K 147 SS=D Continued From page 1

Electrical wiring and equipment is in accordance with NFPA 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 ensure electrical panels were labeled properly, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, twenty (20) residents, staff and visitors.

The findings included:

Observation on 02/11/15 at 11:55 AM, with Maintenance, revealed one (1) electrical panel, Panel A, near Nurse Unit #2 desk was not labeled properly, indicated what the circuit breakers operated. Interview, with Maintenance, revealed the facility had not identified the electrical panels as missing labels indicating what the circuit breakers operated.

The findings were acknowledged by the Administrator at the exit conference.

Reference: NFPA 70 (1999 Edition)

110-22. Identification of Disconnecting Means. Each disconnecting means required by this Code for motors and appliances, and each service, feeder, or branch circuit at the point where it originates, shall be legibly marked to indicate its

K 147 **K147 D Electrical wiring is in accordance with NFPA 70.**

**Corrective Action for Targeted Residents**  
No Residents were directly affected by this practice although the facility realizes that there was a potential to affect one (1) of seven (7) smoke compartments (20) residents, staff and visitors in this smoke compartment area located on Unit 2. On 2-12-15 the facility Maintenance Director and the Assistant Maintenance Director identified the 9 circuit breakers found not to be labeled on breaker panel "A" and marked them with the appropriate area in which the circuit breakers operated.

**Identification of Other Residents with Potential to be affected:**  
All residents have the potential to be affected. An audit was performed by Maintenance on February 12, 2015 of all breakers panels to ensure all circuit breakers in use were properly labeled. No other issues were found.

**Systemic changes**  
On February 12, 2015, the Maintenance Director in-serviced all Maintenance staff on K147 tag.

On February 27, 2015 the facility Life Safety team which consists of the Maintenance Director, Administrator, Social Services Director, Central Supply Clerk, Housekeeping Supervisor, Dietary Director,

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K 147 Continued From page 2  
purpose unless located and arranged so the purpose is evident. The marking shall be of sufficient durability to withstand the environment involved. Where circuit breakers or fuses are applied in compliance with the series combination ratings marked on the equipment by the manufacturer, the equipment enclosure(s) shall be legibly marked in the field to indicate the equipment has been applied with a series combination rating. The marking shall be readily visible and state the following:  
**CAUTION - SERIES COMBINATION SYSTEM RATED \_\_\_\_\_ AMPERES. IDENTIFIED. REPLACEMENT COMPONENTS REQUIRED.**  
FPN: See Section 240-83(c) for interrupting rating marking for end-use equipment.

K 147 Human Resource Generalist and the Activities Director met and discussed K147 tag, and what the plan of correction would be.

An in-service for all the facility's staff was presented March 5-7, 2015 by the Director of Nursing and Assistant Director of Nursing to include the tag K147 and reporting any findings regarding circuit breakers to Maintenance immediately.

**Monitoring**  
The Maintenance Department has added the checking of circuit breakers labels for proper identification to a monthly audit sheet.

Results of the audits will be submitted to the Quality Assurance Performance Improvement committee (QAPI) for review and revision until the Quality Assurance Performance Improvement committee has determined 100% compliance has been achieved.

3-8-2015

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185248</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - NEW ADDITION</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/18/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SAYRE CHRISTIAN VILLAGE NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3775 BELLEAU WOOD DRIVE</b> <b>LEXINGTON, KY 40517</b>		
(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  Based on the facility's acceptable plan of correction, the facility was deemed to be in compliance on 03/08/15 as alleged.	{K 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(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.

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

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NAME OF PROVIDER OR SUPPLIER  SAYRE CHRISTIAN VILLAGE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3775 BELLEAU WOOD DRIVE LEXINGTON, KY 40517
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a) Building: 02 Plan Approval: 3/14/2011 Survey under: NFPA 101 (2000 Edition), Chapter 18 (new health care) Facility type: SNF/NF Type Of Structure: Two (2) stories Type II (111) Unprotected Smoke Compartment: Two (2) Fire Alarm: Complete fire alarm (new installation) Sprinkler System: Complete automatic sprinkler system (new installation) Generator: Type II, Diesel (new installation)</p> <p>A Standard Life Safety Code Survey was initiated and concluded on 02/11/15. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility (New Edition) was found to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred thirty (130) beds and the census was one hundred twenty three (123) the day of the survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ann Scoson</i>	TITLE Administrator	(X6) DATE 3/18/15
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NAME OF PROVIDER OR SUPPLIER  SAYRE CHRISTIAN VILLAGE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3775 BELLEAU WOOD DRIVE LEXINGTON, KY 40517
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Plan Approval: 1982</p> <p>Survey under: NFPA 101 (2000 Edition), Chapter 19 (existing health care)</p> <p>Facility type: SNF/NF</p> <p>Type Of Structure: One (1) story Type V (111) Protected</p> <p>Smoke Compartment: 5</p> <p>Fire Alarm: Complete fire alarm</p> <p>Sprinkler System: Complete automatic sprinkler system</p> <p>A Standard Life Safety Code Survey was initiated and concluded on 02/11/15. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred thirty (130) beds and the census was one hundred twenty three (123) the day of the survey.</p> <p>Deficiencies were cited with the highest Scope and Severity of an "D".</p>	K 000	<p>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.</p>	<p>2/18/2015</p>
K 147	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *3/18/15*

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K 147  
SS=D

Continued From page 1  
Electrical wiring and equipment is in accordance with NFPA 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 ensure electrical panels were labeled properly, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, twenty (20) residents, staff and visitors.

The findings included:

Observation on 02/11/15 at 11:55 AM, with Maintenance, revealed one (1) electrical panel, Panel A, near Nurse Unit #2 desk was not labeled properly, indicated what the circuit breakers operated. Interview, with Maintenance, revealed the facility had not identified the electrical panels as missing labels indicating what the circuit breakers operated.

The findings were acknowledged by the Administrator at the exit conference.

Reference: NFPA 70 (1999 Edition)

110-22. Identification of Disconnecting Means.  
Each disconnecting means required by this Code for motors and appliances, and each service, feeder, or branch circuit at the point where it originates, shall be legibly marked to indicate its

K 147

**K147 D Electrical wiring is in accordance with NFPA 70.**

**Corrective Action for Targeted Residents**

No Residents were directly affected by this practice although the facility realizes that there was a potential to affect one (1) of seven (7) smoke compartments (20) residents, staff and visitors in this smoke compartment area located on Unit 2. On 2-12-15 the facility Maintenance Director and the Assistant Maintenance Director identified the 9 circuit breakers found not to be labeled on breaker panel "A" and marked them with the appropriate area in which the circuit breakers operated.

**Identification of Other Residents with Potential to be affected:**

All residents have the potential to be affected. An audit was performed by Maintenance on February 12, 2015 of all breakers panels to ensure all circuit breakers in use were properly labeled. No other issues were found.

**Systemic changes**

On February 12, 2015, the Maintenance Director in-serviced all Maintenance staff on K147 tag.

On February 27, 2015 the facility Life Safety team which consists of the Maintenance Director, Administrator, Social Services Director, Central Supply Clerk, Housekeeping Supervisor, Dietary Director,

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K 147 Continued From page 2  
purpose unless located and arranged so the purpose is evident. The marking shall be of sufficient durability to withstand the environment involved. Where circuit breakers or fuses are applied in compliance with the series combination ratings marked on the equipment by the manufacturer, the equipment enclosure(s) shall be legibly marked in the field to indicate the equipment has been applied with a series combination rating. The marking shall be readily visible and state the following:  
**CAUTION - SERIES COMBINATION SYSTEM RATED \_\_\_\_\_ AMPERES. IDENTIFIED. REPLACEMENT COMPONENTS REQUIRED.**  
FPN: See Section 240-83(c) for interrupting rating marking for end-use equipment.

K 147 Human Resource Generalist and the Activities Director met and discussed K147 tag, and what the plan of correction would be.

An in-service for all the facility's staff was presented March 5-7, 2015 by the Director of Nursing and Assistant Director of Nursing to include the tag K147 and reporting any findings regarding circuit breakers to Maintenance immediately.

**Monitoring**

The Maintenance Department has added the checking of circuit breakers labels for proper identification to a monthly audit sheet.

Results of the audits will be submitted to the Quality Assurance Performance Improvement committee (QAPI) for review and revision until the Quality Assurance Performance Improvement committee has determined 100% compliance has been achieved.

3-8-2015