

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

PRINTED: 07/03/2025
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 R 05/29/2025
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}	<p>INITIAL COMMENTS</p> <p>An off-site Revisit/Follow-up Survey was initiated and concluded on 05/29/2025. It was determined the facility had corrected their deficiencies on 05/19/2025 as alleged.</p> <p>Based upon the implementation of the acceptable Plan of Correction, the facility was deemed to have corrected their deficiencies on 05/19/2025, as alleged.</p>	{F 000}			

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

TITLE

(X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185248	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2025
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 and Abbreviated Survey was concluded on 04/24/2025. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. No deficiencies were issued related to KY00041911, KY00041991, KY00042055, KY00044568, and KY00044569. Survey Dates: 04/21/2025 - 04/24/2025 Survey Census: 162 Sample Size: 34 Supplemental Residents: 32	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, the facility failed to ensure the resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 2 of 4 sampled residents, Resident (R) 34 and R120. The findings include: Review of the facility's policy titled, "Call Lights: Accessibility and Timely Response," revised 01/30/2025, revealed staff would ensure the call	F 558	The filing of this plan of correction does not constitute an admission of guilt to the alleged deficient practices and is not in fact an admission that they exist. This plan of correction is filed as evidence of the facility to comply with the requirements of participation and to continue to provide high quality resident care. 1. Resident #34 had the potential to be	5/19/25

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

TITLE

(X6) DATE

Electronically Signed

05/17/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185248	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/24/2025
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 558	<p>Continued From page 1</p> <p>light was within reach of the resident and secured as needed. Further review revealed the call system would be accessible to residents while in their bed or other sleeping accommodations within the resident's room.</p> <p>Review of the facility's policy titled, "Resident Rights," undated, revealed the resident had the right to a dignified existence and self-determination.</p> <p>Review of the facility's policy titled, "Safe and Homelike Environment," undated, revealed the facility would provide a safe, clean, comfortable, and homelike environment.</p> <p>1. Review of R34's "Admission Record" revealed the facility admitted the resident on 12/05/2024 with diagnoses including acute lymphoblastic lymphoma (ALL), urine retention, and chronic obstructive pulmonary disease (COPD).</p> <p>Review of the R34's quarterly "Minimum Data Set [MDS]" with an Assessment Reference Date (ARD) of 03/07/2025, revealed the facility assessed the resident to have a "Brief Interview for Mental Status [BIMS]" score of 13 out of 15, which indicated the resident was cognitively intact. Further review revealed the resident required substantial to maximum assistance with bed mobility and was dependent on staff for transfers.</p> <p>Review of R34's "Care Plan Report," with a revision date of 12/10/2024, revealed the resident required assistance from staff with activities of daily living (ADL).</p> <p>Observation on 04/22/2025 at 8:54 AM and again</p>	F 558	<p>affected by the alleged deficient practice. On 4.28.25 a call light clip was attached to residents call light chord to ensure call light remained within reach by Admissions Coordinator.</p> <p>Resident #120 had the potential to be affected by the alleged deficient practice. Maintenance replaced the bed with a wider bed for Resident #120 on 4.25.25.</p> <p>2.A room-to-room audit was completed on 4.28.25 by the Admission Coordinator to identify residents who had the potential to be affected by the alleged deficient practice. Clips were placed on all call light cords to ensure that call lights remained within reach by the Admission Coordinator.</p> <p>Room audits for Residents with a BIMS score of 7 and below was completed by Unit Managers for 100, 200,300, and 400 on 5.13.25 to ensure resident needs and reasonable accommodations were met. Residents with a BIMS of 8 or above were interviewed by SSDs for Units 100,200,300 and 400, Activity Directors, and/or Operations Assistant to ensure resident needs and reasonable accommodations were being met by 5.13.25.</p> <p>Any issues identified were corrected immediately and reported to the Director of Nursing or Administrator.</p> <p>3.All current nursing staff, environmental staff, activity staff, dietary staff, and maintenance staff were reeducated by the</p>		

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 04/24/2025
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 558	<p>Continued From page 2</p> <p>on 04/22/2025 at 11:22 AM revealed R34 was asleep in her bed. However, the call light was observed on the floor and out of the resident's reach.</p> <p>In an interview on 04/23/2025 at 9:32 AM, State Registered Nurse Aide (SRNA) 3 stated it was important residents' call lights were within their reach for safety purposes. She further stated if the call light was out of reach, residents felt unprotected. SRNA3 stated the call light should never be on the floor.</p> <p>In an interview with SRNA11 on 04/24/2025 at 9:54 AM, she stated residents' call lights should always be within their reach because it was a safety issue. She stated if a resident needed assistance, it was important for staff to be notified.</p> <p>In an interview with Licensed Practical Nurse (LPN) 1 on 04/24/2025 at 10:18 AM, she stated access to staff was important when residents needed help, and the call light should always be within their reach.</p> <p>2. Review of R120's "Admission Record" revealed the facility admitted the resident on 01/30/2025 with diagnoses including cerebral infarction (stroke) and Alzheimer's disease.</p> <p>Review of R120's admission "MDS," with an ARD of 02/06/2025, revealed the resident had a "BIMS" score of 14 out of 15, which indicated the resident was cognitively intact.</p> <p>Observation on 04/21/2025 at 1:42 PM revealed R120 in her room sitting up in the recliner.</p>	F 558	<p>Administrator, Director of Nursing, Staff Development, Unit 100 Coordinator, Unit 200 Coordinator, or Unit 300 Coordinator. Education included but not limited to: ensuring call lights are in reach of residents at all times and if the call light cord does not have a clip to secure in place to let the appropriate Unit Manager know immediately. The Unit Managers will replace call light clips as needed. Education was completed by Administrator 5.18.2025.</p> <p>All current staff were educated on ensuring resident needs and reasonable accommodations are being met by the Administrator, Director of Nursing, Social Service Directors or Operations Assistant by 5.18.25, including any needs or accommodations by the resident or family. Education included reporting requests to the appropriate Unit Manager, Social Service Director, or if a maintenance need to initiate a work order.</p> <p>Any staff not completing education by 5.18.25 will not be allowed to work the floor until education is completed.</p> <p>A post education quiz will be administered to ensure understanding.</p> <p>Any issues identified were corrected immediately and reported to the Director of Nursing or Administrator.</p> <p>4. The Admissions coordinator, Administrator, or Operations Assistant will</p>		

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 04/24/2025
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 558	<p>Continued From page 3</p> <p>Observation on 04/22/2025 at 8:34 AM revealed R120 asleep in her recliner.</p> <p>In an interview with R120 on 04/21/2025 at 1:42 PM, she stated she slept in the recliner each night. She further stated she was not able to sleep in her bed because it was uncomfortable and small; and the facility was supposed to have it replaced.</p> <p>In an additional interview with R120 on 04/22/2025 at 1:31 PM, she stated again that the bed in her room was uncomfortable. She stated she spoke to someone at the facility about it, but no one had responded. R120 stated she was not sure who she spoke with, but thought it was about a week or so ago. R120 stated she preferred a bed rather than a recliner when she slept.</p> <p>In an interview with the Social Services Director (SSD) on 04/23/2025 at 3:41 PM, she stated she was notified of a problem with R120's bed about a week ago. She further stated she was not sure exactly what the issue was; but something about the bed being too narrow, and R120 slept in her recliner. The SSD stated she thought perhaps the resident was a little claustrophobic. She further stated it was her responsibility to make sure someone followed up with the resident. The SSD stated she had not followed up with R120 but should have.</p> <p>In an interview with R120's Representative on 04/24/2025 at 3:47 PM, she stated the resident had not slept in a recliner at home. She further stated she was not sure what the issue was with the bed at the facility, but R120 slept in a bed when she was at home.</p>	F 558	<p>audit 10 residents per day Monday thru Friday to ensure call lights are in reach of resident and each cord has a clip to secure in place, the following 2 weeks the admissions coordinator, Administrator, or Operations Assistant will audit 5 residents per day, reducing to 1 resident per day for 2 weeks. Any issues identified will be corrected immediately and reported to the Director of Nursing or Administrator.</p> <p>The Maintenance Director or designee will monitor work orders for any reasonable accommodation requests in the work order system Monday thru Friday for 2 weeks. The Social Service Directors, Operations Assistant, or Unit Managers will do 10 random interviews Monday thru Friday for 2 weeks to ensure that resident needs and reasonable accommodations are being met. The following 2 weeks the SSD, Operations Assistant, or Unit Managers will do 5 random interviews to ensure that resident needs and reasonable accommodations are being met, reducing to 1 resident per week for 2 weeks.</p> <p>Any issues identified were corrected immediately and reported to the Director of Nursing or Administrator.</p> <p>The results of the audits will be reported to the QAA committee for 3 months for follow up and any further recommendations.</p>		

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 04/24/2025
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 558	Continued From page 4 In an interview on 04/24/2025 at 4:29 PM, the Director of Nursing (DON) stated she expected all staff would answer call lights, and if the resident's need was not in their scope of practice, appropriate staff would be contacted. She further stated a call light should never be left on the floor or anywhere out of a resident's reach because they needed access to staff at all times. The DON stated they had several residents at the facility that preferred a recliner over a bed, and she was not aware of an issue with R120's bed. In an interview with the Administrator on 04/24/2025 at 5:06 PM, she stated it was her expectation call lights were placed on the bed within the resident's reach, and on the floor was not acceptable. She stated she had not received a grievance or complaint from R120, or her family related to the need for a different bed. She further stated that was an issue that should have been brought to her attention immediately and appropriately resolved.	F 558			
F 847 SS=E	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of	F 847		5/19/25	

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

PRINTED: 07/03/2025
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 04/24/2025
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 847	<p>Continued From page 5</p> <p>his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.</p> <p>§483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement;</p> <p>§483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.</p> <p>§483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.</p> <p>§483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of</p>	F 847	1.Residents # 32,58,117,127, and 131		

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 04/24/2025
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 847	<p>Continued From page 6</p> <p>the facility's documents, the facility failed to ensure residents and resident representatives were informed, using appropriate language, that binding arbitration agreements explicitly were not required as a condition of admission explicitly provided the residents or resident representatives the right to rescind the agreement within 30 days of signing it for 5 of 5 residents reviewed for arbitration agreements, Resident (R) 32, R58, R117, R127, and R131.</p> <p>Additionally, interview with three residents (R58, R127, R131) that signed agreements, including one as recently as 04/01/2025 (R131), did not recall the discussion of arbitration or signing of arbitration agreements.</p> <p>The findings include:</p> <p>Review of the facility's document "Arbitration and Mediation" agreement, not dated, revealed appropriate verbiage was not included on the form. The form did not indicate it was an optional form for the resident to complete; did not indicate it was not a requirement for the resident's admission; and did not indicate residents or representatives had 30 days to rescind the form after signing.</p> <p>In interviews with the five residents present for the Resident Council meeting on 04/22/2025 at 1:26 PM, they stated none of them recalled signing any arbitration agreement. After the State Survey Agency (SSA) Surveyor described the arbitration document as a form that should have been identified as not a requirement to sign for admission, they still did not recall signing any arbitration agreement.</p>	F 847	<p>had the potential to be affected by the alleged deficient practice.</p> <p>Residents and/or Representative received an updated Arbitration agreement which was explained in detail. Each Resident or Representative has signed as excepting or declining the updated Arbitration Agreement by 5.15.25.</p> <p>No residents were identified as having a negative outcome related to the alleged deficient practice.</p> <p>2.All newly admitted residents have the potential to be affected by the alleged deficient practice. A retrospective review of all arbitration agreements signed within the last 30 days was completed by Admissions Director, Billing Specialist, Operations Assistant, or Administrator by 5.8.2025. Each agreement was reviewed for proper documentation of:</p> <p>Resident/responsible party signature, Date of signing, Evidence that the agreement was explained in an understandable manner, Confirmation that the agreement was not a condition of admission, Notice of the 30-day right to rescind.</p> <p>Each resident or Representative signed either accepting or declining the Arbitration agreement and that they understood the contents of the agreement by 5.15.25.</p>		

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 04/24/2025
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 847	<p>Continued From page 7</p> <p>Review of R32's and R117's "Arbitration and Mediation" agreement revealed both forms were signed by responsible parties and did not include required verbiage indicating it was not a requirement for admission and could be rescinded within 30 days of signing.</p> <p>Review of R58's and R127's "Arbitration and Mediation" agreement revealed both residents had signed their own arbitration agreements, which did not include require verbiage indicating it was not a requirement for admission and could be rescinded within 30 days of signing. R58 signed her document on 08/15/2023, and R127 signed his document on 05/30/2024.</p> <p>Review of the facility's new electronic health records (EHR) revealed R131 was classified as a new admission. Per the record, the facility admitted R131 on 04/01/2025, and she signed her own arbitration agreement.</p> <p>In an interview with R131 on 04/23/2025 at 8:17 AM, she stated "there's so many things, if it said to sign it, then I signed it." She stated she thought the forms in the admission packet were for insurance. She stated the word "arbitration" did not sound familiar to her, and an arbitration form was not explained to her in detail.</p> <p>In an interview with the Admissions Coordinator (AC) on 04/22/2025 at 3:36 PM, she stated she had been trained on presentation and completion of "Arbitration and Mediation" forms by the Administrator. The AC stated she went over and read the agreement to residents or the responsible party. She stated she shared that they had the option not to sign but was not aware residents or representatives had the right to</p>	F 847	<p>3.The Admissions Director, Billing Specialist, and Operations Assistant, were educated and trained on regulatory wording and communicating to residents and/or Representatives by the Administrator on 4.22.25. Assistant will verify every other admission/ readmission to ensure proper Arbitration is being used, then will reduce to 1 admission being monitored in the next 2 weeks.</p> <p>All staff were educated on updated Arbitration Agreement including appropriate language from the regulatory guidelines by the Administrator or Designee by 5.18.25.</p> <p>Staff who have not completed education by 5.18.25 will not be allowed to work the floor until education is completed.</p> <p>A post education quiz will be administered to ensure understanding.</p> <p>Any concerns noted will be corrected immediately with reeducation and reported to the QAA committee for 3 months for any further recommendations.</p>		

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

PRINTED: 07/03/2025
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 04/24/2025
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 847	Continued From page 8 rescind arbitration agreements within 30 days of signing. She stated the "Arbitration and Mediation" document was part of about 70 other pages she reviewed with residents or representatives as part of the admissions process. In an interview with the Administrator on 04/23/2025 at 1:16 PM, she stated when arbitration was first introduced it was mandatory for admission, which was overturned in 2022. She stated since, it had been explained to residents and representatives as voluntary. She stated in August 2024 it was turned over to attorneys to be made into a separate document. The Administrator stated the facility had not yet received a revised document. The Administrator stated some residents or representatives did refuse to sign, so they were clearly presenting the arbitration agreement as not a condition of admission. The Administrator stated that, even though the facility dealt with this every day and understood residents and representatives were not required to sign the form as a condition of admission, she could understand the importance of residents and families knowing it was not a condition of admission. The Administrator stated initial paperwork for admission took an hour and a half to two hours to complete, and quite often, even higher functioning residents were tired coming from hospitals and would ask if their family or power-of-attorney (POA) could complete paperwork for them.	F 847			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		5/19/25	

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 04/24/2025
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 880	<p>Continued From page 9</p> <p>infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p>	F 880			

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 04/24/2025
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 880	<p>Continued From page 10</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility document review, Centers for Disease Control and Prevention guidelines, and facility policy review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 6 of 34 sampled residents, Resident (R) 11, R34, R36, R119, R125, and R150.</p>	F 880	<p>1. Residents number 11, 34,36,125,150, and 119 had the potential to be affected by the alleged deficient practice. These residents were checked by 5.2.25 by Unit Managers for Units 100, 200, and 300 for signs and symptoms of infection including but not limited to temperature, change in behavior, or change of overall condition.</p> <p>No residents displayed a negative outcome due to the alleged deficient practice.</p>		

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 04/24/2025
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 880	<p>Continued From page 11</p> <p>Observations revealed R11 and R34 had indwelling urinary catheter drainage bags resting on the floor; a gait belt was used on R36 without its prior disinfection; a blood pressure cuff was used on R125 and not disinfected after its use; R150's medications were placed on an unclean surface without using a barrier; R119's food was handled by a staff member with ungloved hands; and a dietary staff member's badge was resting in a resident's food.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Infection Surveillance," dated 01/01/2025 revealed its purpose was to identify infections and to monitor adherence to recommended infection prevention and control practices to reduce infections and prevent the spread of infections.</p> <p>Review of the facility's policy titled, "Catheter Care, Urinary," revised 08/2022, revealed the catheter tubing and catheter drainage bag were kept off the floor.</p> <p>Review of the facility's policy titled, "Cleaning and Disinfection of Resident-Care Equipment," dated 01/01/2025, revealed that "reusable resident-care equipment will be cleaned and disinfected in accordance with current Centers for Disease Control and Prevention (CDC) recommendations." The policy stated, "Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident." The policy stated, "Multiple-resident use equipment shall be cleaned and disinfected after each use." The policy stated, "Use only Environmental Protection Agency (EPA)-registered disinfectants</p>	F 880	<p>2. All residents had the potential to be affected by the alleged deficient practice. Residents were monitored for signs and symptoms of infection including but not limited to temperature, change in behavior, or overall change in condition, by 5.2.25 beginning by Unit Managers for Units 100,200, and 300.</p> <p>No residents displayed negative outcomes related to the alleged deficient practice.</p> <p>All identified concerns were addressed immediately and reported to the Director of Nursing, Administrator, or Infection Preventionist.</p> <p>3. All current staff were reeducated on proper infection control procedures including but not limited to: proper catheter care, sanitizing equipment in between uses of residents, proper medication pass procedures, and food handling by the Infection Preventionist/Staff Development, Administrator, Director of Nursing, Unit Managers on 100,200, and 300. Education was completed by 5.18.25.</p> <p>All dietary staff received badge reels to replace lanyards on 5.12.25 from the Food Service Director. Education on contaminated food including contamination by name badge touching food was completed on 5.18.25 by the Administrator or Food Service Director.</p> <p>Any staff not completing education by</p>		

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 04/24/2025
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 880	<p>Continued From page 12</p> <p>with kill claims for the common organisms found in the facility."</p> <p>Review of the CDC's Guidelines "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated 09/10/2021, revealed reusable medical equipment should be cleaned and disinfected according to manufacturer's instructions or the facility's policies before and after use. Further review of the guidelines revealed staff should be trained in the correct steps for cleaning and disinfection of shared equipment.</p> <p>Review of the facility's "[Facility] Employee Handbook," dated 01/01/2024, regarding employee identification badges, revealed, "Staff must wear identification badges visibly above the waist and in front of the body. Badges may not be clipped onto sleeves. Staff must be aware of lanyards, metal clips, and pins during resident care. Breakaway lanyards are required for safety."</p> <p>1. Observation on 04/21/2025 at 1:52 PM revealed the Physical Therapy/Occupational Therapy assistant (PTA/OTA) used a gait belt for R147 and then placed the gait belt around her neck without cleaning/disinfecting it. The PTA/OTA then used the same gait belt on R36, ambulated her to the Activities Room, removed the gait belt, and placed it back around her neck without cleaning/disinfecting it. The PTA/OTA then cleaned the handles on the walker that was used with R36 with hand sanitizer from the hall.</p> <p>During an interview with the PTA/OTA on 04/21/2025 at 2:03 PM, she stated she normally</p>	F 880	<p>5.18.25 will not be allowed to work their shift until education is completed.</p> <p>A post education quiz will be administered to ensure understanding.</p> <p>4. All residents with catheters will be monitored daily for 2 weeks to ensure drainage bags are not touching the floor and have a dignity bag in place by Operations Assistant, VP of Quality and Compliance, Director of Nursing, Unit managers for 100, 200, 300, or Infection Preventionist. All residents with catheters will be monitored 3 times weekly for 2 additional weeks by Operations Assistant, VP of Quality and Compliance, Director of Nursing, Unit managers for 100, 200, 300, or Infection Preventionist. All residents with catheters will be monitored once per day for the next two weeks by Operations Assistant, VP of Quality and Compliance, Director of Nursing, Unit managers for 100, 200, 300, or Infection Preventionist.</p> <p>Any concerns identified will be corrected immediately and reported to the Administrator or Director of Nursing for follow up and reported to the QAA Committee for 3 months for further recommendations and review.</p> <p>Operations Assistant, VP of Quality and Compliance, Director of Nursing, Unit managers for 100, 200, 300, or Infection Preventionist will observe 10 uses of medical equipment to include gait belts and blood pressure cuffs between residents daily for 2 weeks. Operations</p>		

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 04/24/2025
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 880	<p>Continued From page 13</p> <p>used a disinfectant spray to disinfect the gait belt, but she had left the spray downstairs in the office. She stated she cleaned the walker with sanitizer but was not sure what the policy stated.</p> <p>2.a. Review of R34's "Admission Record" revealed the facility admitted the resident on 12/05/2024 with diagnoses including acute lymphoblastic lymphoma (ALL), urinary retention, and chronic obstructive pulmonary disease (COPD).</p> <p>Review of R34's quarterly "Minimum Data Set [MDS]," with an Assessment Reference Date (ARD) of 03/07/2025, revealed the facility assessed the resident to have a "Brief Interview for Mental Status [BIMS]" score of 13 out of 15, which indicated the resident was cognitively intact. Further review revealed the resident was admitted with an indwelling urinary catheter.</p> <p>Review of a "Physician's Order" found in R34's electronic medical record (EMR) revealed an active order, dated 12/05/2024, that specified indwelling urinary catheter care every shift for neurogenic bladder.</p> <p>Review of the R34's "Care Plan Report," revised 12/10/2024, revealed a problem of altered urinary elimination related to the use of an indwelling catheter with an increased risk for urinary tract infection (UTI) related to neurogenic bladder and urinary retention.</p> <p>Observation on 04/22/2025 at 8:54 AM revealed R34 asleep in bed; the urinary catheter was positioned on the far side of the resident's bed, and the drainage bag was located on the floor.</p>	F 880	<p>Assistant, VP of Quality and Compliance, Director of Nursing, Unit managers for 100, 200, 300, or Infection Preventionist will observe 5 uses of medical equipment to include gait belts and blood pressure cuffs between residents daily for the following 2 weeks. Operations Assistant, VP of Quality and Compliance, Director of Nursing, Unit managers for 100, 200, 300, or Infection Preventionist will observe 1 uses of medical equipment to include gait belts and blood pressure cuffs between residents daily for the following 2 weeks.</p> <p>All concerns identified will be addressed immediately, reported to the DON, IP, or Administrator, and reported to the QAA Committee for the following 3 months for further recommendations and review.</p> <p>Operations Assistant, VP of Quality and Compliance, Director of Nursing, Unit managers for 100, 200, 300, or Infection Preventionist will observe 10 transactions of food handling daily for 2 weeks. Operations Assistant, VP of Quality and Compliance, Director of Nursing, Unit managers for 100, 200, 300, or Infection Preventionist will observe 5 transactions of food handling daily for 2 weeks. Operations Assistant, VP of Quality and Compliance, Director of Nursing, Unit managers for 100, 200, 300, or Infection Preventionist will observe 1 transactions of food handling once daily for 2 weeks.</p> <p>The Administrator or Food Service Director will monitor food line daily Monday thru Friday for 2 weeks to ensure</p>		

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 04/24/2025
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 880	<p>Continued From page 14</p> <p>Additional observation of R34 on 04/22/2025 at 11:22 AM again revealed the catheter positioned on the resident's bed with the drainage bag on the floor.</p> <p>b. Review of R11's "Admission Record" revealed the facility admitted the resident on 01/21/2025 with diagnoses including Non-Hodgkin lymphoma, personal history of UTIs, and Alzheimer's disease.</p> <p>Review of R11's admission "MDS," with an ARD of 01/28/2025, revealed the facility assessed the resident to have a "BIMS" score of three out of 15, which indicated the resident was severely cognitively impaired. Further review revealed the resident was admitted with an indwelling urinary catheter.</p> <p>Review of a "Physician's Order found in R11's EMR revealed an active order, dated 04/02/2025, that specified indwelling urinary catheter care every shift and as needed.</p> <p>Review of the R11's "Care Plan Report," dated 04/11/2025, revealed a problem of altered urinary elimination related to the use of an indwelling catheter.</p> <p>Observation on 04/22/2025 at 11:15 AM revealed R11 in her room seated in a recliner. R11 had an indwelling urinary catheter attached to the recliner with the drainage bag observed on the floor.</p> <p>In an interview with State Registered Nurse Aide (SRNA) 3 on 04/23/2025 at 9:32 AM, she stated she provided catheter care every time she changed R34 and as needed. She further stated the catheter drainage bags were positioned on</p>	F 880	<p>no contamination of food by foreign objects including name badges. The following 2 weeks, the Administrator or Food Service Director will monitor food line daily for 3 days per week. The following 2 weeks, the Administrator or Food Service Director will monitor food line daily for 1 day per week</p> <p>Any concerns identified will be reported to the Administrator or Director of Nursing for follow up and reported to the QAA Committee for 3 months for further recommendations and review.</p> <p>VP of Quality and Compliance, Director of Nursing, Unit managers for 100, 200, 300, or Infection Preventionist will observe 10 transactions of medication passes daily for 2 weeks. VP of Quality and Compliance, Director of Nursing, Unit managers for 100, 200, 300, or Infection Preventionist will observe 5 transactions of medication passes daily for 2 weeks. VP of Quality and Compliance, Director of Nursing, Unit managers for 100, 200, 300, or Infection Preventionist will observe one transaction of medication pass daily for 2 weeks.</p> <p>All concerns identified will be addressed immediately, reported to the DON, IP, or Administrator, and reported to the QAA Committee for the following 3 months for further recommendations and review.</p>		

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 04/24/2025
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 880	<p>Continued From page 15</p> <p>the bed lower than the level of a resident's bladder, covered with a dignity bag, and not placed on the floor because of infection concerns. SRNA3 stated if she observed a catheter bag on the floor, she notified nursing so the resident could be assessed before the bag was changed.</p> <p>In an interview with SRNA4 on 04/23/2025 at 9:50 AM, she stated staff received frequent in-services related to infection control, and catheter care was sometimes one of the topics. SRNA4 stated a catheter was positioned low on the bed, but the collection bag was never placed on the floor because of bacteria and the risk for infection.</p> <p>In an interview on 04/23/2025 at 9:54 AM, SRNA11 stated she checked residents' catheters each time she rounded on them. She stated catheters should be lower than the level of the bladder so they drained properly, and the collection bag should be off the floor because of possible contamination and infection.</p> <p>In an interview with Licensed Practical Nurse (LPN) 5 on 04/24/2025 at 10:05 AM, she stated she typically rounded on residents between SRNA rounds, so they were seen at least every hour. She further stated catheter drainage bags should be below the resident and off the floor, so they were kept clean, which reduced the potential for infection. LPN5 stated in the past, on her rounds, she had observed catheter drainage bags on the floor, but they were replaced immediately.</p> <p>In an interview with LPN 1 on 04/24/2025 at 10:18 PM, she stated she expected catheter drainage bags to be protected with dignity covers for privacy and to be kept off the floor. Additionally, she stated if the drainage bags were on the floor,</p>	F 880			

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 04/24/2025
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 880	<p>Continued From page 16</p> <p>it put the resident at risk for infection.</p> <p>In an interview on 04/24/2025 at 12:34 PM, the Infection Preventionist (IP) stated infection control training and education began at orientation. He further stated the facility also held annual trainings that covered infection control as well as regular infection control and prevention in-services. The IP stated it was his expectation that catheter drainage bags were always kept off the floor because that presented an infection risk for the resident.</p> <p>In an interview on 04/24/2025 at 4:29 PM with the Director of Nursing (DON), the DON stated catheter drainage bags should always be kept off the floor due to the potential risk for infection to the resident.</p> <p>In an interview on 04/24/2025 at 5:06 PM, the Administrator stated she expected catheter drainage bags to be always kept off the floor because of the potential risk for infection.</p> <p>3. Observation on 04/22/2025 at 9:00 AM revealed Kentucky Medication Aide (KMA) 1 used a blood pressure (BP) cuff on R125, then placed it back into the medication cart without cleaning/disinfecting it.</p> <p>In an interview on 04/22/2025 at 10:13 AM with KMA1, she stated BP cuffs should be cleaned between each resident with the purple top Sani-Wipes (an EPA registered disinfectant).</p> <p>In an interview on 04/22/2025 at 10:24 AM with Registered Nurse (RN) 1, she stated shared equipment should be cleaned between each use. She stated she used hand sanitizer to clean shared equipment, and she was unsure what the</p>	F 880			

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 04/24/2025
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 880	<p>Continued From page 17 policy stated.</p> <p>In an interview on 04/23/2025 at 3:14 PM with SRNA7, she stated shared equipment was cleaned between each resident use with the purple top Sani-Wipes. She stated she would not use hand sanitizer and had not been taught that.</p> <p>4. Observation on 04/22/2025 at 9:20 AM revealed KMA1 poured R150's medications onto the tablecloth in the dining room, without using a barrier, for R150 to self-administer medications.</p> <p>In continued interview on 04/22/2025 at 10:13 AM with KMA1, she stated she should have placed a barrier for medications placed on the tablecloth for R150 to self-administer. She stated tablecloths were normally cleaned daily, but she was unsure who changed them out.</p> <p>5. Observation on 04/22/2025 at 12:20 PM revealed RN1 handled R119's chicken salad sandwich, breaking it in half, without wearing any gloves.</p> <p>In additional interview on 04/24/2025 at 8:40 AM with RN1, she stated she should have worn gloves while handling resident foods. She stated that was important to prevent contamination.</p> <p>In an interview on 04/24/2025 at 8:30 AM with the Infection Prevention/Wound Care Nurse (IP/WOCN), he stated shared equipment should be cleaned/disinfected before and between resident use with the purple top Sani-Wipes. He stated hand sanitizer should not be used as a disinfectant for shared equipment. He stated a barrier should always be used when pouring medications on a surface, and "no direct contact</p>	F 880			

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 04/24/2025
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 880	<p>Continued From page 18 with food is permitted."</p> <p>In an interview on 04/24/2025 at 4:29 PM with the Director of Nursing (DON), she stated shared equipment should be cleaned/disinfected between every use to decrease the spread of germs and diseases between residents. The DON stated hand sanitizer should never be used in place of Sani-Wipes. The DON stated staff should not be pouring medications on an uncleaned surface, and the medication cup should be handed to residents, or a clean barrier should be used. She stated gloves should be worn when handling resident food to prevent germs and cross contamination.</p> <p>In an interview on 04/24/2025 at 5:14 PM with the Administrator, she stated shared equipment should be cleaned/disinfected between each resident with Sani-Wipes, and hand sanitizer should never be used on equipment. She stated staff should not be handing foods without gloves on. She stated medications should never be poured onto an unsanitary surface for residents to self-administer for infection prevention and safety.</p> <p>6. Observation on 04/23/2025 at 11:27 AM revealed the Cook leaning over a dish of mechanically soft beef to take a food temperature on an adjacent dish, with her identification badge resting in the mechanically soft beef.</p> <p>In an interview on 04/23/2025 at 2:20 PM, the Cook stated she "wears her badge around her neck and keeps it tucked inside her apron during plating and temping [taking food temperatures]." She stated the facility policy required staff to keep badges "on and connected to you and not hanging around food." She stated she had not received specific training on securing her badge</p>	F 880			

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 04/24/2025
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 880	<p>Continued From page 19</p> <p>during food service. She stated she understood the requirement to wear gloves or use utensils when handling food and understood the importance of preventing foreign objects from contacting food. She stated, "Contaminated food must be removed from the line and placed in the dirty dish room." She stated she was unaware her badge had contacted food when she took food temperatures that morning.</p> <p>In an interview on 04/23/2025 at 2:28 PM, the Dietary Manager stated policy required staff to wear badges between the waist and shoulder, close to the body, on breakaway lanyards for safety. He stated no separate dietary-specific policy existed. He stated residents were a vulnerable population and emphasized the critical importance of preventing food contamination. He stated he expected staff to remove, discard, and replace any food contacted by a foreign object.</p> <p>In an interview on 04/24/2025 at 5:28 PM, the Administrator stated contaminated food constituted an infection control issue. She stated after the incident was reported, she reviewed the handbook and confirmed the requirement for breakaway lanyards. She stated she would obtain badge reels for dietary staff.</p> <p>In continued interview on 04/24/2025 at 4:29 PM with the DON, she stated she expected all staff to follow facility policies and procedures related to infection control and prevention. She further stated she constantly walked the halls and monitored for compliance.</p> <p>In continued interview on 04/24/2025 at 5:14 PM with the Administrator, she stated she expected all staff to follow the facility's infection control</p>	F 880			

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

PRINTED: 07/03/2025
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 04/24/2025
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 880	Continued From page 20 policies to maintain a safe environment for residents.	F 880			

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100544	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 05/29/2025
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)
{N 000}	<p>Initial Comments</p> <p>An off-site Revisit/Follow-up Survey was initiated and concluded on 05/29/2025. It was determined the facility had corrected their deficiencies on 05/19/2025 as alleged.</p> <p>Based upon the implementation of the acceptable Plan of Correction, the facility was deemed to have corrected their deficiencies on 05/19/2025, as alleged.</p>	{N 000}	

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

TITLE

(X6) DATE

Electronically Signed

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100544	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2025
--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

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) COMPLETE DATE
N 000	<p>Initial Comments</p> <p>A Relicensure and Complaint Survey was initiated on 04/21/2025 and concluded on 04/24/2025. The facility was found to have regulatory violations. Complaints KY00041911, KY00041991, KY00042055, KY00044568, and KY00044569 were unsubstantiated with no deficient practice identified related to the complaints. Survey Census: 162.</p>	N 000		

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

Electronically Signed

TITLE

(X6) DATE

05/17/25

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

PRINTED: 07/03/2025
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 04/23/2025
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	
E 000	<p>Initial Comments</p> <p>42 CFR 483.73</p> <p>Type of Structure: Two (2) story with a partial basement, (1982, 2011), Type V (111), protected combustible construction with 10 smoke compartments and a complete automatic wet and dry sprinkler system.</p> <p>An Emergency Preparedness Recertification Survey was conducted on 04/23/2025, in accordance with 42 Code of Federal Regulations, Subpart 483.73 (a)(3): (emergency preparedness) Requirements for Long Term Care Facilities. During this Recertification Survey, Sayre Christian Village Nursing Home was found to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p>	E 000			

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

TITLE

(X6) DATE

Electronically Signed

05/15/2025

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

PRINTED: 07/03/2025
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 06/17/2025
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
{K 000}	INITIAL COMMENTS Based on the acceptable Plan of Correction (POC) and the onsite revisit survey initiated and concluded on 06/17/2025, it was determined the facility had achieved substantial compliance with Life Safety Code on 05/15/2025.	{K 000}		

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

TITLE

(X6) DATE

Electronically Signed

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

PRINTED: 07/03/2025
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/23/2025
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
K 000	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 1982, 2011 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: Two (2) story with a partial basement, (1982, 2011), Type V (111), protected combustible construction with 10 smoke compartments and a complete automatic wet and dry sprinkler system. A Life Safety Recertification Survey was initiated on 04/23/2025 and concluded on 04/23/2025, in accordance with 42 Code of Federal Regulations (CFR), Subpart 483:90(a) Requirements for Long Term Care Facilities. During this Recertification Survey, Sayre Christian Village Nursing Home was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The requirement at 42 CFR, Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used,	K 222		5/15/25

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

TITLE

(X6) DATE

Electronically Signed

05/15/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185248	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/23/2025
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	
K 222	<p>Continued From page 1</p> <p>only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.</p> <p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6</p> <p>SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p> <p>DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.</p> <p>18.2.2.2.4, 19.2.2.2.4</p>	K 222			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185248	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/23/2025
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	
K 222	<p>Continued From page 2</p> <p>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</p> <p>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to make provisions for the rapid removal of occupants through delayed egress locks on exit doors in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) of 11 egress doors, staff, and 10 residents. The facility had the capacity for 164 beds with a census of 158 on the day of the survey.</p> <p>The findings include:</p> <p>Observation, during the building inspection tour on 04/23/2025 at 3:00 PM, revealed the delayed egress door located on Hall Two (2) was marked with the signage "PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 15 SECONDS", however upon testing; the door could not be opened for 30 seconds.</p> <p>Interview, on 04/23/2025 at 3:01 PM with the Maintenance Manager, revealed the facility was not aware the delayed egress door would not release within the time stated on the signage.</p> <p>The finding was verified by the Maintenance</p>	K 222	<p>The filing of this plan of correction does not constitute an admission of guilt to the alleged deficient practices and is not in fact an admission that they exist. This plan of correction is filed as evidence of the facility to comply with the requirements of participation and to continue to provide high quality resident care.</p> <p>1. 10 residents had the potential to be affected by the alleged deficient practice. No residents had a negative outcome based on the alleged deficient practice.</p> <p>2. Residents on Unit 200 had the potential to be affected by alleged deficient practice. All Egress doors were inspected by the Maintenance Director on 4.22.25, for proper compliance and functioning. No residents on Unit 200 had a negative outcome related to the alleged deficient practice.</p> <p>3. Schiller Hardware was on sight on</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185248	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/23/2025
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	
K 222	<p>Continued From page 3</p> <p>Manager at the time of observation and by the Administrator at the exit conference on 04/23/2025.</p> <p>Actual NFPA Standard: NFPA 101 Life Safety Code, (2012)</p> <p>19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted by one of the following:</p> <p>(1) Locks complying with 19.2.2.2.5 shall be permitted.</p> <p>(2) *Delayed-egress locks complying with 7.2.1.6.1 shall be permitted</p> <p>(3) *Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.</p> <p>(4) Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted.</p> <p>(5) Approved existing door-locking installations shall be permitted.</p> <p>7.2.1.6.1 Delayed-Egress Locking Systems.</p> <p>7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided that all of the following criteria are met:</p> <p>(1) The door leaves shall unlock in the direction of egress upon actuation of one of the following:</p> <p>(a) Approved, supervised automatic sprinkler system in accordance with Section 9.7</p> <p>(b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6</p>	K 222	<p>5.2.25 to make necessary adjustments to door #2 allowing for proper release of 15 seconds. The Maintenance Director confirmed proper functioning of door #2 on 5.2.25.</p> <p>All staff will be educated by the Administrator, Maintenance Director, or designee, on proper function and release times of egress doors. Education will be completed by 5.18.25. Education includes notification to the Maintenance Director or Administrator immediately of any issues with egress doors function.</p> <p>Any staff not completing education by 5.18.25 will not be allowed to work the floor until education is completed.</p> <p>A post education quiz will be administered to ensure understanding.</p> <p>4.Maintenance staff or designee will monitor all egress doors for proper functioning daily 5 times per week Monday through Friday for two weeks. Thereafter, 3 times per week for two weeks. Concluding with one time per week for two weeks.</p> <p>Any concerns identified will be reported to QAA committee for 3 months for follow-up and further recommendations.</p>		

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

PRINTED: 07/03/2025
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 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/23/2025
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	
K 222	Continued From page 4 (c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6 (2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism. (3) *An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (4) *A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1/8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS (5) The egress side of doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with Section 7.9.	K 222			
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 372		5/15/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185248	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/23/2025
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	
K 372	<p>Continued From page 5</p> <p>Construction 2012 EXISTING</p> <p>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall.</p> <p>Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.</p> <p>19.3.7.3, 8.6.7.1(1)</p> <p>Describe any mechanical smoke control system in REMARKS.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke barriers could restrict the transfer of smoke in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect three (3) of nine (9) smoke barrier walls, staff, and 40 residents. The facility had capacity for 164 beds with a census of 158 on the day of the survey.</p> <p>The findings include:</p> <p>1). Observation, during the building inspection tour on 04/23/2025 at 11:06 AM, revealed the smoke barrier wall located above the cross-corridor doors entering Unit Two (2) had a two (2) inch cable penetration through both sides of the wall that would not resist the passage of smoke. Interview, on 04/23/2025 at 11:07 AM with the Maintenance Manager, revealed the facility was not aware of the unsealed penetration in the wall.</p>	K 372	<p>1.40 residents had the potential to be affected by the alleged deficiency. No residents had negative outcomes related to the alleged deficient practice.</p> <p>2.Any residents within the 3 smoke compartments had the potential to be affected by the alleged deficient practice.</p> <p>All firewalls were inspected by the Maintenance Director on 04.22.25 for penetrations. No other concerns were identified.</p> <p>No residents had a negative outcome related to the alleged deficient practice.</p> <p>3.The Maintenance Director, maintenance staff, or designee will seal all penetrations by 05.16.25.</p> <p>All staff will be educated by the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185248	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/23/2025
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
K 372	Continued From page 6 2). Observation, during the building inspection tour on 04/23/2025 at 11:15 AM, revealed the smoke barrier wall located above the cross-corridor doors by the 200 Nurse Station had a two (2) inch cable penetration that would not resist the passage of smoke. Interview, on 04/23/2025 at 11:16 AM with the Maintenance Manager, revealed the facility was not aware of the unsealed penetration in the wall. 3). Observation, during the building inspection tour on 04/23/2025 at 11:18 AM, revealed the smoke barrier wall located above the cross-corridor doors by the Life Enrichment Center had a one (1) inch cable penetration through both sides of the wall that would not resist the passage of smoke. Interview, on 04/23/2025 at 11:19 AM with the Maintenance Manager, revealed the facility was not aware of the unsealed penetration in the wall. 4). Observation, during the building inspection tour on 04/23/2025 at 11:21 AM, revealed the smoke barrier located above the cross-corridor doors by the Life Enrichment Center had a three (3) inch cable penetration in the wall that would not resist the passage of smoke. Interview, on 04/23/2025 at 11:22 AM with the Maintenance Manager, revealed the facility was not aware of the unsealed penetration in the wall. The findings were verified by the Maintenance Manager at the time of observations and the Administrator at the exit conference on 04/23/2025. Actual NFPA Standard: NFPA 101 Life Safety Code, (2012)	K 372	Administrator, Maintenance Director or designee on regulatory guidelines in relation to fire wall penetration by 05.18.25. Any staff not completing education will not be allowed to work the floor until education is completed. A post education quiz will be administered to ensure understanding. 4.The Maintenance Director, maintenance staff or designee will monitor all firewalls for any penetrations daily 5 times per week Monday through Friday for 2 weeks. Thereafter, 3 times per week for 2 weeks. Concluding with 1 time per week for 2 weeks. Any concerns identified will be corrected immediately and reported to the Maintenance Director, Administrator or maintenance staff. Any concerns identified will be reported to QAA committee for further follow-up or recommendations for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185248	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/23/2025
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	
K 372	Continued From page 7 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1-2-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). (b) Not less than two separate smoke compartments shall be provided on each floor. (2)*Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. 8.5.6.2 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke.	K 372			
K 781 SS=D	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed	K 781		5/15/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185248	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/23/2025
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
K 781	<p>Continued From page 8</p> <p>212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure portable space heaters used in the facility were in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) portable space heating device, staff, and three (3) residents. The facility had the capacity for 164 beds with a census of 158 on the day of the survey.</p> <p>The findings include:</p> <p>Observation, during the building inspection tour on 04/23/2025 at 4:15 PM, revealed the facility failed to provide documentation that a heat producing electrical fireplace located in the 300 Hall Dayroom area had a heating element that did not exceed 212 degrees Fahrenheit.</p> <p>Interview, on 04/23/2025 at 4:16 PM with the Maintenance Manager, revealed the facility was aware of the requirements for portable heaters but was not aware that the electric fireplace had a functional heat producing element.</p> <p>The finding was verified by the Maintenance Manager at the time of observation and the Administrator at the exit conference on 04/23/2025.</p> <p>Actual NFPA Standard: NFPA 101 Life Safety Code, (2012) 19.7.8 Portable Space-Heating Devices. Portable space heating devices shall be prohibited in all health care occupancies, unless both of the</p>	K 781	<p>1.3 residents had the potential to be affected by alleged deficient practice. No residents had negative outcomes related to alleged deficient practice.</p> <p>2.Any residents in the common area on unit 300 had the potential to be affected by the alleged deficient practice. No other residents were identified to have negative outcomes related to the alleged deficient practice.</p> <p>The Maintenance Director conducted a facility-wide audit to ensure no space heaters were in use on 04.23.25.</p> <p>Any space heaters identified to be in use were removed immediately and reported to the Administrator.</p> <p>3.The Maintenance Director disconnected the heating element to the electric fireplace on Unit 300 on 04.23.25.</p> <p>All staff were educated by the Administrator, Maintenance Director or designee, on policies relating to prohibiting use of space heaters in the facility by 05.18.25.</p> <p>Any staff not completing the education by 5.18.25 will not be allowed to work the floor until education is completed.</p> <p>A post education quiz will be administered</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185248	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/23/2025
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
K 781	Continued From page 9 following criteria are met: (1) Such devices are used only in nonsleeping staff and employee areas. (2) The heating elements of such devices do not exceed 212°F (100°C).	K 781	to ensure understanding. 4.The Maintenance Director, Maintenance staff or designee will conduct 10 random room checks daily Monday through Friday for 2 weeks. Thereafter, 5 rooms per day Monday through Friday for 2 weeks. Concluding with 1 room per day for 2 weeks Monday through Friday. Any concerns identified will be corrected immediately and reported to the Maintenance Director or Administrator. Any concerns identified will be reported to the QAA committee for 3 months for follow-up and further recommendations.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure.	K 920		5/15/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185248	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/23/2025
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	
K 920	<p>Continued From page 10</p> <p>Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.</p> <p>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain power strips in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect 50 rooms, staff, and 75 residents. The facility had the capacity for 164 beds with a census of 158 on the day of the survey.</p> <p>The findings include:</p> <p>1). Observation, during the building inspection tour on 04/23/2025 at 2:00 PM, revealed a refrigerator plugged into a power strip, overloading the rating, located in the Unit Coordinator Office in Unit One (1). Interview, on 04/23/2025 at 2:01 PM with the Maintenance Manager, revealed the facility was not aware of the refrigerator being plugged into a power strip.</p> <p>2). Observation, during the building inspection tour on 04/23/2025 between 2:10 PM and 3:05 PM, revealed rated power strips, not part of an assembly located within six (6) feet of the resident beds and being used for personal electronics throughout the 100 and 200 Halls of the facility. Interview, on 04/23/2025 at 3:06 PM with the Maintenance Manager, revealed the facility had a misunderstanding of the rated power strip usage and thought they could be used for</p>	K 920	<p>1.75 residents had the potential to be affected by alleged deficient practice. No residents had negative outcomes related to the alleged deficient practice.</p> <p>2.All residents had the potential to be affected by alleged deficient practice. The Maintenance Director and maintenance staff conducted a facility-wide audit to assess any power cords not being used according to regulations by 05.16.25.</p> <p>All power cords not being used according to regulations were removed by the Maintenance Director and maintenance staff by 05.15.25.</p> <p>No residents had negative outcomes relating to the alleged deficient practice.</p> <p>3.The Chief Operating Officer relayed education to the residents and families via mass communication email on 04.28.25 and in-person (by the Maintenance Director or Administrator) as needed on regulatory guidelines related to proper use of power cords in facility as well as potential hazards related to improper use. The Administrator, Maintenance Director and maintenance staff will work with</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185248	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/23/2025
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
K 920	<p>Continued From page 11 personal electronics.</p> <p>3). Observation, during the building inspection tour on 04/23/2025 at 2:40 PM, revealed a power strip plugged into a power strip for personal electronics located in Resident Room 204. Interview, on 04/23/2025 at 2:41 PM with the Maintenance Manager, revealed the facility was not aware of the power strip being plugged into another power strip.</p> <p>The findings were verified by the Maintenance Manager at the time of observation and the Administrator at the exit conference on 04/23/2025.</p> <p>Actual NFPA Standard: NFPA 99 Health Care Facilities Code, (2012) 10.2.4 Adapters and Extension Cords. 10.2.4.1 Three-prong to two-prong adapters shall not be permitted. 10.2.4.2 Adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. 10.2.4.2.1 All adapters shall be listed for the purpose. 10.2.4.2.2 Attachment plugs and fittings shall be listed for the purpose. 10.2.4.2.3 The cabling shall comply with 10.2.3 10.2.3.2 Grounding Conductor. 10.2.3.2.1 Each electric appliance shall be provided with a grounding conductor in its power cord.</p> <p>Actual NFPA Standard: NFPA 70 National Electrical Code, (2011) 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure</p>	K 920	<p>individual residents on a case-by-case basis if additional power sources are needed.</p> <p>All staff were educated by the Administrator on regulatory guidelines relating to proper use of power cords in facility as well as potential hazards related to improper use by 05.18.25.</p> <p>Any staff not completing education prior to 5.18.25 will not be allowed to work the floor until education is completed.</p> <p>A post education quiz will be administered to ensure understanding.</p> <p>4.The Maintenance Director, maintenance staff or designee will conduct 10 random room checks daily Monday through Friday for 2 weeks. Thereafter, 5 rooms per day Monday through Friday for 2 weeks. Concluding with 1 room per day for 2 weeks Monday through Friday.</p> <p>Any concerns identified will be corrected immediately and reported to the Maintenance Director or Administrator.</p> <p>Any concerns identified will be reported to the QAA meeting for 3 months for further follow-up and recommendations.</p>	

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

PRINTED: 07/03/2025
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 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/23/2025
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
K 920	Continued From page 12 (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings 4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage	K 920		