

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

PRINTED: 06/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ROYAL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE: 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
---	--

(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 Standard Recertification and Abbreviated Survey Investigating KY#000KY18402 was Initiated on 05/22/12 and concluded on 05/24/12. KY#00018402 was unsubstantiated. Deficiencies were cited with the highest scope/severity of an "E".	F 000	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement to the alleged cited deficiencies. Royal Manor, Inc. submits this Plan of Correction as evidence of adherence to state and federal requirements for licensure and participation in the Medicare and Medicaid programs	
F 323 SS=E	483.26(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to ensure the residents' environment remained as free from accident hazards as possible. Observations during the initial tour and environmental tour revealed the facility failed to ensure disinfectant cleaner, shampoo, body lotion, manicure sticks with sharp points, and hand sanitizer were secured/locked and not accessible to residents. In addition, the facility failed to ensure a hair dryer was unplugged and not located in a sink. The findings include: Review of the facility's policy titled, "Transport to	F 323 F 323	This document is not intended to waive any defense, legal or equitable, in administrative, civil, or criminal proceedings. F 323 Accidents and Supervision This facility shall ensure that the resident environment remains free of accident hazards as is possible; and ensure each resident receives adequate supervision and assistive devices to prevent accidents	6-14-12

RECEIVED
JUN 14 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 6-14-12
---	----------------------------	--------------------------

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

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

PRINTED: 06/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ROYAL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
---	---

(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 323	<p>Continued From page 1</p> <p>Shower Room/Shower Chair Safety Policy and Procedure", dated 04/05/12, revealed under Procedure #3, it stated to check bathing room for clutter, safety concerns, and cleanliness and under Procedure #5 it stated after the bath/shower, gather personal hygiene supplies (powders, lotions, deodorant, brush, comb, razors, shaving cream, etc.).</p> <p>Review of the facility's policy titled, "Tub Bath or Shower Policy and Procedure ", dated 04/05/12, revealed under Procedure #3, to transport resident to shower room with personal items. The policy further stated under #10 to transport the resident back to his or her room with personal items.</p> <p>Review of the Resident Census and Conditions, received from the facility on 05/22/12, revealed there were fifty-nine (59) residents with thirty-three (33) listed under Section C with Dementia.</p> <p>Review of the Wander Gard list, received from the facility on 05/23/12, revealed four (4) residents were at risk for wandering.</p> <p>Observed during the initial tour of the facility, on 05/22/12 at 10:00AM, of the Shower Room on Hall A, revealed Equate Dandruff Shampoo, Personal Hand Sanitizer, personal care items such as Cocoa Butter, razors, hair dryer, curling iron, and manicure sticks with sharp points. Further observation revealed a pair of glasses and a pair of shoes were in the tub.</p> <p>Observation of the Shower Room on Hall B, on 05/22/12 at 11:50 AM, revealed four (4) hair</p>	F 323	<p>What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>A one time 100% audit was completed on 5/22/12 when issue was identified to the Administrator by the Survey Team. This Audit was completed by the Administrator-In-Training and Quality Assurance Director at approximately 1830 to remove items from the shower room. All potentially hazardous items identified were removed.</p> <p>The staff member who left the Hair Dryer Identified by the Survey team in the shower room was immediately disciplined per facility policy.</p> <p>An Emergency Quality Assurance Meeting was held at 1900 on 5/22/12 in order to correct potential deficient practice related to Shower Room Safety which was identified by the survey team that day. The Quality Assurance Team Drafted and Adopted a new policy at that time "Shower Room Safety."</p>	6-14-12

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

PRINTED: 06/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED. C 05/24/2012
--	---	--	--

NAME OF PROVIDER OR SUPPLIER ROYAL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 323	<p>Continued From page 2</p> <p>brushes, a hair dryer, curling iron, several manicure sticks with sharp points, Crest ProHealth Mouth Wash, a fly swatter, and a bottle of Lysol cleaner were in an unlocked cabinet. In addition, a manicure stick was observed loose on the floor.</p> <p>Continued observation, on 06/22/12 from 4:36 PM until 6:16 PM, revealed the items listed above remained in the Shower Room on Hall B. In addition, the hair dryer was plugged into the wall and was lying in the sink along with a bottle of baby powder. The cabinet on the wall was open and contained an aerosol can of personal body spray, a bottle of 70% Isopropyl Alcohol, hand sanitizing gel, razors, and manicure sticks.</p> <p>Review of the Material Safety Data Sheet (MSDS) for Crest Pro Health Rinse revealed the product to have the potential to produce transient superficial irritation to the eye and ingestion of large amounts may produce signs of stomach irritation.</p> <p>Review of the MSDS sheet for Equate Medicated Dandruff Shampoo revealed the product to have the potential to produce irritation to the eyes and ingestion may cause gastrointestinal irritation, nausea, vomiting and diarrhea.</p> <p>Review of the MSDS sheet for Cocoa Butter revealed the product to have the potential to produce irritation to the eye and ingestion may cause gastrointestinal irritation, nausea, vomiting, and diarrhea.</p> <p>Review of the MSDS sheet for Endure Revitalizing Skin Lotion revealed the product to</p>	F 323	<p>The policy states that the Nurses are to inspect shower rooms upon coming onto shift, this includes making sure that no hazards or potentially cross contaminated items are in the shower rooms. Hair Dryers and Curling Irons shall be kept at the Nurses Station and will be signed in and out as needed for care.</p> <p>The policy went into effect on 5-22-12 and all nursing staff were in-serviced prior to working their next shift.</p> <p>How will the Royal Manor identify other residents having the potential to be affected by the same deficient practice?</p> <p>All resident's had the potential to be affected by this deficient practice.</p>	6-14-12

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

PRINTED: 06/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ROYAL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY. 40356
---	--

(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.323	<p>Continued From page 3 have the potential to cause mild eye irritation.</p> <p>Review of the MSDS sheet for Purell Hand Sanitizer with Aloe revealed the product to have the potential to cause eye irritation, upset stomach, or nausea.</p> <p>Review of the MSDS sheet for Isopropyl Alcohol revealed the product to have the potential health effects of: irritation to the respiratory tract if inhaled along with exposure to high concentrations to have a narcotic effect producing symptoms of dizziness, drowsiness, headache, staggering, unconsciousness, and possibly death. Further review showed ingestion could cause drowsiness, unconsciousness, and death. Gastrointestinal pain, cramps, nausea, vomiting, and diarrhea may also result. The single lethal dose for human adult would equal about 250 milliliters (eight (8) ounces). The MSDS continued with warnings of skin irritation with redness and pain and possible systemic effects if absorbed through the skin. The MSDS revealed the vapors of the product could cause eye irritation with splashes causing severe irritation with possible corneal burns, and eye damage.</p> <p>Review of the MSDS sheet for Lysol Cleaner revealed the product to have the potential health effects of irritation to the eyes, irritation to the skin, odors may irritate, and harmful if swallowed. Further review showed signs and symptoms may include redness, edema, drying, defatting and cracking of the skin, headache, dizziness, tiredness, nausea, and vomiting.</p> <p>Interview, on 05/22/12 at 6:15PM, with Certified Nursing Assistant (CNA) #1 revealed she did not</p>	F 323	<p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>The Central Baths have been specifically added to the Safety Committee Rounds sheet. These safety rounds are completed by the Administrator or designee at least weekly.</p> <p>How will Royal Manor plan to monitor its performance to ensure that solutions are sustained?</p> <p>The Safety Rounds are reviewed weekly as part of the Safety Committee Meeting. The Safety Committee Minutes are reviewed monthly by the Quality Assurance Committee.</p>	6-14-12

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

PRINTED: 06/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2012
--	---	--	--

NAME OF PROVIDER OR SUPPLIER ROYAL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40366
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 323	<p>Continued From page 4</p> <p>know the cabinet needed to be closed or locked. Further interview revealed she was unaware that sharps needed to be placed in a sharps container. She also agreed that the hairdryer in the sink plugged in was a "bad idea".</p> <p>Interview, on 06/22/12 at 6:24PM, with CNA #2 revealed the cabinet should at least be closed but she was unsure about locked. Further interview revealed medical attention or poison control would be necessary if residents ingested many of the items in the cabinet and the razors belonged in the sharps box.</p> <p>Interview, on 06/22/12 at 6:28PM, with LNHA #1 revealed all items should be locked up or in a resident's room.</p> <p>Interview, on 06/23/12 at 2:14PM, with Registered Nurse (RN) #1 revealed she thought many residents were at risk for being able to open the door to Shower Room A and therefore they were at risk for harm. She revealed she felt two (2) of the Wander Guard residents could open the shower room door and four (4) other residents with dementia could open it also.</p>	F 323	<p>The Safety Committee is a permanent part of the Quality Assurance program of Royal Manor, however Royal Manor will specifically monitor the Shower Room and its policy for the a period of 1 year to ensure compliance is met, unless the Quality Assurance Team identifies that the monitoring system is not effective, and the Quality Assurance team may develop with an alternative system of monitoring Shower Room Safety.</p> <p>Safety Rounds were completed on 6-1-12 and 6-8-12 per Safety Committee policy. There were no hazards observed.</p> <p>On <u>6-14-12</u> a Safety Round were completed by Royal Manor's Administrator, Director of Nursing, and Quality Assurance Director with no deficient practice observed. An Emergency Q.A. Meeting held on <u>6-14-12</u>. To review Audits related to Royal Manor's P.O.C. related to annual survey 2012. The facility is alleging compliance on <u>6-14-12</u>.</p>	6-14-12

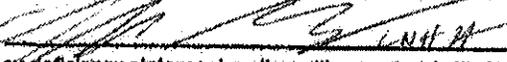
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER ROYAL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40358
---	---

(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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 06/10/75</p> <p>SURVEY UNDER: NFPA 101 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story Type III(200)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system</p> <p>SPRINKLER SYSTEM: Complete (wet) sprinkler system</p> <p>GENERATOR: One (1) Type II Diesel generator.</p> <p>A standard Life Safety Code survey was conducted on 06/22/12. Royal Manor was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for seventy-three (73) beds with a census of sixty-nine (69) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p> <p>Deficiencies were cited with the highest</p>	K 000	<p>Preparation and/or execution of the Plan of Correction does not constitute admission or agreement to the alleged cited deficiencies.</p> <p>Royal Manor, Inc. submits this Plan of Correction as evidence of adherence to state and federal requirements for licensure and participation in the Medicare and Medicaid programs</p> <p>This document is not intended to waive any defense, legal or equitable, in administrative, civil, or criminal proceedings.</p> <div style="text-align: right; border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;"> <p>RECEIVED JUN 14 2012 BY: _____</p> </div>	6-14-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 6-14-12
---	------------------------	----------------------

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

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

PRINTED: 08/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER ROYAL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40366
---	---

(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 K 029 88=D	<p>Continued From page 1 deficiency identified at "E" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were protected according to National Fire Protection Association (NFPA) standards.</p> <p>The findings include:</p> <p>Observation, on 05/22/12 between 10:00 AM and 3:30 PM, with the Maintenance Director revealed the door leading into the food storage in the kitchen area did not have a self closing device installed per NFPA Life Safety Code.</p> <p>Interview, on 05/22/12 between 10:00 AM and 3:30 PM, with the Maintenance Director, revealed he was unaware of this requirement. This was also confirmed with the Administrator during the exit interview.</p>	K 000 K 029	<p>K 029</p> <p>What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>-No residents were affected by the deficient practice. The Door Stopper on the pantry room door was removed on <u>5-22-12</u> and a door closer was added on <u>6-14-12</u>. See Attached Photo 3.</p> <p>How will the Royal Manor identify other residents having the potential to be affected by the same deficient practice?</p> <p>-All residents had the potential to be affected by deficient practice</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>-Add to Safety Rounds specific section on Door Closers/Door Stoppers, to ensure no stoppers are on any door, and spaces with combustible items have door closers on them.</p>	6-14-12

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

PRINTED: 08/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER ROYAL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
---	---

(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 029	<p>Continued From page 2</p> <p>Reference: NFPA 101 (2000 edition) 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ul style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit and directional signs are displayed in accordance with section 7.10 with continuous</p>	K 029	<p>How will Royal Manor plan to monitor its performance to ensure that solutions are sustained?</p> <p>The Safety Committee is a permanent part of the Quality Assurance program of Royal Manor, however Royal Manor will specially monitor the Door Stoppers and Door Closers for the a period of 1 year to ensure compliance is met, unless the Quality Assurance Team identifies that the monitoring system is not effective, and the Quality Assurance team may develop with an alternative system of monitoring Door Stoppers and Door Closers.</p> <p>On 6-14-12 Safety Rounds were completed by Royal Manor's Administrator, Director of Nursing, and Quality Assurance Director with no deficient practice observed. Emergency Q.A. Meeting held on 6-14-12. To review Audits related to Royal Manor's P.O.C. related to annual survey 2012. The facility is alleging compliance on 6-14-12.</p> <p>K 047 Continued on Next Page</p>	6-14-12
K 047 SS=E		K 047		6-14-12

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

PRINTED: 06/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2012
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ROYAL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
--	---

(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 047	<p>Continued From page 3 Illumination also served by the emergency lighting system. 19.2.10.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficiency has the potential to affect one (1) of four (4) smoke compartments, including residents, staff and visitors. The facility is licensed for seventy-three (73) beds with a census of sixty-nine (69) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 05/22/12 between 10:00 AM and 3:30 PM, with the Maintenance Director revealed:</p> <ol style="list-style-type: none"> 1) Combustibles (medical records) were within thirty-six (36) inches of the electrical panel in the Medical Records storage room. 2) Soiled linen containers were stored in front of electrical panels in the laundry room. <p>Interview, on 05/22/12 between 10:00 AM and 3:30 PM, with the Maintenance Director confirmed all observations. He stated he thought that since soiled linen carts were on rollers they could be moved quickly if needed that they could be stored in that area.</p> <p>Reference: NFPA 70 (1999 edition)</p>	K 047	<p>What Corrective Action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>-No residents were affected by the deficient practice. A safety barrier was installed on 6-12-12 in laundry room to keep linen carts/barrels at least 36 inches from the electrical panels. See Attached Photo 1. Shelves in Medical Record room have been removed on 6-12-12. See attached Photo 2.</p> <p>How will the Royal Manor identify other residents having the potential to be affected by the same deficient practice?</p> <p>-All residents had the potential to be affected by deficient practice</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>-Added to Safety Rounds specific section on Electrical Panels</p>	6-14-12

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

PRINTED: 06/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER ROYAL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
---	---

(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 047	<p>Continued From page 4 110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p>	K 047	<p>How will Royal Manor plan to monitor its performance to ensure that solutions are sustained?</p> <p>Safety Rounds are reviewed weekly as part of the Safety Committee Meeting. The Safety Committee Minutes are reviewed monthly by the Quality Assurance Committee.</p> <p>The Safety Committee is a permanent part of the Quality Assurance program of Royal Manor, however Royal Manor will specifically monitor the Electrical Panels for the a period of 1 year to ensure compliance is met, unless the Quality Assurance Team identifies that the monitoring system is not effective, and the Quality Assurance team may develop with an alternative system of monitoring Electrical Panels. On <u>6-14-12</u> Safety Rounds were completed by Royal Manor's Administrator, Director of Nursing, and Quality Assurance Director with no defioient practice observed. Emergency Q.A. Meeting held on <u>6-14-12</u>. To review Audits related to Royal Manor's P.O.C. related to annual survey 2012. The facility is alleging compliance on <u>6-14-12</u>.</p>	6-14-12