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

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Division of Health Care
& Safety Enforcement Branch

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185220	A. BUILDING _____ B. WING _____	C 04/06/2011

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

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F 000	INITIAL COMMENTS A standard health survey was conducted on April 4-6, 2011. Deficient practice was identified with the highest scope and severity at "E" level. An abbreviated standard survey (KY15584) was also conducted at this time. The allegation was unsubstantiated with no deficient practice identified.	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 174 SS=B	483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure residents had reasonable access to the use of a telephone to make private telephone calls. Telephone calls could not be placed/received by residents without being overheard by staff and other residents when the resident was using the residents' telephone in the Restorative Dining area. In addition, the facility's three bedfast residents had no access to a telephone while the resident was maintained on a bedfast status. The findings include: A group interview conducted with ten alert and oriented residents on April 5, 2011, at 3:30 p.m., revealed the only telephone for resident use was located in the resident Restorative Dining area. Observation of the telephone on April 5, 2011, at	F 174	This document is not intended to waive any defense, legal or equitable, in administrative civil, or criminal proceedings. F 174 Right to Telephone Access This facility shall ensure that all residents have reasonable access to the use of a telephone to make private telephone calls as evidenced by: ***What corrective action will be accomplished for those resident found to be affected by the deficient practice?*** A portable phone was purchased for the facility on 4-11-11. The portable phone was placed in front lobby on 4-21-11 ***How will the facility identify other residents having the potential to be affected by the same deficient practice?*** All residents have the potential to be affected. All resident were informed of the portable phone	5-5-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
CNHA	Administrator	5-16-11

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

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F 174	Continued From page 1 5:00 p.m., revealed the telephone was on a desk located adjacent to the resident dining tables. Residents attending the meeting further stated the telephone calls were not private if residents/staff members were using the resident dining area. The residents stated bedfast residents did not have access to a telephone if the residents were to receive telephone calls. An interview was conducted with the facility Activity Director (AD) on April 6, 2011, at 9:00 a.m. The AD stated the only telephone provided for resident use was the telephone in the residents' Restorative Dining room. The AD stated the resident's families were provided with the telephone number to the residents' telephone at the time of the resident's admission to the facility. The AD stated bedfast residents would have no access to a telephone if the resident was unable to get out of bed to use the telephone located in the dining room. Interviews were conducted on April 6, 2011, at 9:00 a.m. through 9:40 a.m., with three bedfast residents (residents #4, #17, and #18) taken from a list provided by the facility. Interview with resident #18 on April 6, 2011, at 9:00 a.m., revealed the resident had a telephone in the resident's room. According to the resident, the resident's family had provided payment for a telephone to be placed in the resident's room due to the resident's inability to access the telephone in the dining room. Resident #17 stated his/her family paid for the resident to have a telephone in the resident's room because of the resident's inability to get out	F 174	installation on 4-26-11 by the Social Service Director. ***What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?*** The Social Services Director has informed all current residents of the portable phone availability and that an office may be provided for complete privacy if requested as of 4-26-11. This information has been added to the admission packet as of 4-26-11. The Social Service Director will monitor the portable phone weekly to insure it is working properly. The Social Services Director will weekly remind the bed bound residents of the portable phone availability. This will be recorded on a form and turned into the Staff Development Coordinator weekly. This new monitoring system began on 4-26-11. All nursing staff will receive in-service training regarding the availability of the portable phone. The in-service training began on 4-27-11 and shall be completed no later than 5-5-11 by the Social Service Director. During new staff orientation everyone will be informed of the phone policy.	

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F 174	Continued From page 2 of bed to use the dining room telephone. Resident #4 stated she could not get out of bed to have access to the telephone located in the dining room. The resident further stated his/her spouse would be pleased if they could speak over the telephone.	F 174	***How will the facility monitor its performance to ensure that solutions are sustained?*** The quality assurance team will review the Social Service Directors monitoring sheet monthly to ensure compliance. After a period of one year the Quality Assurance team will meet to assess the need to continue reviewing the monitoring sheet monthly.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225	F225 This facility shall ensure that no individual will be involved in any form of mistreatment, neglect or abuse including injuries of unknown source and/or misappropriation of the resident property without knowledge of Administration and this facility shall conduct thorough investigations to identify patterns, trends and occurrences that may constitute alleged incidence of abuse, as evidenced by: ***What corrective action will be accomplished for those resident found to be affected by the deficient practice?*** The safety committee investigated possible abuse related to referenced skin tears on 4-8-11 for both Resident #1 and #4. No conclusive evidence of abuse was noted.	5-5-11

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F 225	Continued From page 3 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed conduct a thorough investigation to identify patterns, trends, and occurrences that may constitute abuse related to incidence of skin tears for two of nineteen sampled residents (residents #1 and #4). The findings include: A review of the facility's Abuse policy/procedure (no date) revealed interventions to identify, investigate, and prevent further occurrences of mistreatment, abuse, and neglect would be initiated. The policy/procedure noted the incident investigations would be logged/tracked and reviewed for any evidence of abusive behaviors or negligence. 1. Resident #4 was admitted to the facility on December 20, 2010. The resident's diagnoses included lower extremity deep vein thrombosis, Stage IV decubitus on right ischium and left foot, and Alzheimer's disease. A review of the Care Plan for resident #4 dated December 20, 2010, revealed resident #4 was at risk for impaired skin integrity with a listed goal for	F 225	Residents #1 and #4 have a separate care plan specific for skin tears initiated on 4-6-11 with resident specific, resident appropriate interventions for the prevention of further skin tears. ***How will the facility identify other residents having the potential to be affected by the same deficient practice?*** All residents will receive a head-to-toe skin assessment. These assessments will be completed no later than 5-2-11. The Safety Committee will review upon completion. All findings will be recorded, tracked, treated and updates made to the care plan as needed. ***What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?*** A new policy/procedure regarding how to identify patterns, trends and occurrences that may constitute abuse related to skin impairment was adopted on 4-5-11. An in-service was held on 4-7-11 regarding new Policy and Procedure of Skin Impairment, including assessment and reporting of skin tears. Included in this in-service was the abuse policy and procedure that includes immediate notification, and reporting. This in-service was conducted by the Administrator and Director of Nursing.	

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F 225	Continued From page 4 "no further breakdown(s)." Interventions noted on the care plan were for staff to use caution with all transfers to prevent skin tears. A review of the Nurse's Notes/Physician's Orders for resident #4 revealed the resident received skin tears on January 4 and 19, 2011, February 8, 15, 18, and 19, 2011, and March 3, 2011. There was no documented evidence to prove the facility had investigated the skin tear/bruising incident(s). Observation of resident #4 was conducted on April 5, 2011, at 9:30 a.m. The resident's right upper arm was observed to have a skin tear with bruising noted around the site. The skin tear was covered with a clear dressing. The resident's lower right arm was observed to have a large purple bruise. In addition the resident had a bruise on his/her upper chest. The resident was not interviewed due to short-term memory loss. An interview was conducted with the facility MDS Coordinator on April 5, 2011, at 10:30 a.m. The MDS Coordinator was unsure how the skin tear and bruising on resident #4's right upper/lower arm and chest area had occurred. The MDS Coordinator stated skin tears and bruising were not routinely investigated at the time of the occurrence. An interview was conducted with the facility Director of Nursing (DON) on April 5, 2011, at 10:30 a.m. The DON stated the facility did not complete incident reports on each skin tear/bruise, nor did the facility track and trend skin tear incidents for potential abuse. An interview was conducted with the facility	F 225	Additional in-servicing on Abuse Policy and Procedure and Skin Impairment Policy and Procedure began on 4-26-11 and shall be completed no later than 5-5-11. The in-servicing has been/will be conducted by the Social Service Director and Staff Development Coordinator to insure compliance. ***How will the facility monitor its performance to ensure that solutions are sustained?*** The safety committee will meet weekly in order to track and trend all skin impairments. Interventions will be activated and care planned. The Safety Committee will continue to meet weekly for 1 year in or to ensure compliance has been meet. After a period of 1 year the Quality Assurance team will assess the need for the Safety Committee to meet weekly. As a part of Quality Assurance minutes from the safety committee will be reviewed monthly, for 1 year to ensure compliance has been met. After a period of 1 year the Quality Assurance team will assess the need to review the Safety Committee minutes monthly.	

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F 225	Continued From page 5 Administrator on April 5, 2011, at 10:00 a.m. The Administrator stated skin tears/bruises were not considered to be incidents and the staff did not routinely investigate them for causative factors, trends, patterns, and occurrences. 2. A review of the medical record revealed resident #1 was admitted to the facility on January 19, 2009, with diagnoses to include Alzheimer's, Hypertension, Debility, Dementia with depressive and behavioral disturbances, and Atypical Psychosis. Resident #1 was observed on March 4, 2011, at 4:30 p.m., to be sitting in a wheelchair with a padded cushion on the resident's right side. The resident was leaning to the right side. Resident #1 was not interviewable due to cognitive impairment. A skin assessment conducted on April 6, 2011, at 1:25 p.m., revealed resident #1 had two open wounds to the left buttock/coccyx area. No other skin breakdown was observed. A review of the annual comprehensive assessment conducted on January 7, 2011, revealed resident #1 was assessed to require extensive assistance of two staff persons for transfers and dressing, and total assistance of two for bed mobility. A review of the incident report dated March 28, 2011, revealed resident #1 sustained a skin tear to the left lower extremity (measuring "2-3 inch in length and 1/2 inch in width") while being transferred from the wheelchair to the bed. The incident report noted the resident did not have a history of skin tears. However, there was no evidence the facility had conducted a thorough	F 225		

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F 225	Continued From page 6 investigation into the incident to determine if there was evidence that possible abuse or neglect had occurred during the transfer for resident #1. On April 2, 2011, resident #1 again sustained a skin tear to the left forearm area (measuring approximately 2 inches) when being assisted to dress by facility staff. A review of the incident report dated April 2, 2011, revealed a direct care staff person was dressing the resident and the staff person's thumb "shifted" causing a tear in the resident's skin. The report noted resident #1 required total assistance and "sometimes" was resistant to care, "i.e. pulling." However, there was no evidence the facility had conducted a thorough investigation into the incident to determine if there was evidence of possible abuse or neglect. An interview conducted with the Director of Nursing (DON) on April 5, 2011, at 10:30 a.m., revealed the facility did not complete incident reports on each skin tear/bruise, nor did the facility track and trend skin tear incidents for potential abuse/neglect. An interview conducted with the facility Administrator on April 5, 2011, at 10:00 a.m., revealed the facility did not consider skin tears/bruises to be an incident. The Administrator stated skin tears/bruises were not routinely investigated for causal factors, trends, and occurrences. In addition, the Administrator stated the incident reports regarding skin tears/bruises were not reviewed/evaluated for indicators of possible abuse or neglect.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226	F 226 This facility has a policy and procedure that prohibits mistreatment, neglect, and abuse of residents and misappropriation of resident property evidenced by:	4-26-11

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F 226	Continued From page 7 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to implement developed policies and procedures to prohibit mistreatment/abuse of residents. A review of employee files revealed the facility failed to conduct required background screenings for two of five sampled employees (employees #3 and #4). The findings include: A review of the facility's Abuse policy/procedure (no date) revealed three methods of screening would be utilized to ensure individuals with a history of substantiated abuse allegations would not be employed by the facility. The screenings were identified as: obtain a state police record, verify status with the Nurse Aide Abuse Registry and any other appropriate licensing board, and check reference with previous employers. A review of the employee file for employee #3 revealed the employee was hired at the facility on March 23, 2011, in the Housekeeping Department. A criminal background check and verification with the Abuse Registry were conducted; however, there was no evidence the facility had conducted any reference checks with the employee's previous employers prior to	F 226	***What corrective action will be accomplished for those resident found to be affected by the deficient practice?*** Background checks were completed prior to end of survey, 4-6-11 and revealed no record of abuse. ***How will the facility identify other residents having the potential to be affected by the same deficient practice?*** A 100% audit of all employee files was completed on 4-26-11. The results of the audit revealed no employees with a history of abuse, and/or felonies. ***What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?*** A double check requiring two signatures on each chart to insure that all background checks, abuse registry checks, and references were checked prior to hire. Intervention began on 4-26-11. ***How will the facility monitor its performance to ensure that solutions are sustained?***	

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F 226	Continued From page 8 employment at the facility. A review of the employee file for employee #4 revealed the employee was hired at the facility on March 22, 2011, in the Dietary Department. A criminal background check and verification with the Abuse Registry were conducted; however, there was no evidence the facility had conducted any reference checks with the employee's previous employers prior to employment at the facility. An interview conducted on April 6, 2011, at 4:25 p.m., with the Office Manager (OM) revealed the background screenings were required to be checked from the employee's previous employer. The OM stated the previous employers generally only provided the employee's dates of service and this was not documented. The OM stated he/she had not contacted the previous employers for employees #3 and #4.	F 226	The quality assurance team will monitor staff development hiring practices monthly to ensure that all persons considered for employment have received a criminal background check, an abuse record check, and references were checked before employed by this facility. The Quality assurance team will review all new hires criminal background checks for a period of 1 year in order to ensure compliance. After 1 year the Quality Assurance team will assess the need to review all new hires criminal background check, abuse record check, and references.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain housekeeping and maintenance services necessary to maintain a sanitary, comfortable, and orderly environment. During the	F 253	F 253 This facility shall provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior evidenced by: ***What corrective action will be accomplished for those resident found to be affected by the deficient practice?*** Corrections for all hazards began immediately upon notification to the facility. Most were corrected prior to survey completion. Shower chairs- Repaired/replaced on 4-21-11.	4-29-11

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F 253	Continued From page 9 environmental tour on April 4-6, 2011, the following observations were noted: four shower chairs were frayed with rough edges; a black mold-like substance was observed on the tiles in the shower stalls in the A and B Wing shower rooms; the whirlpool in the B Wing shower room had sharp/rough edges; nine residents had wheelchair arms that were cracked/rough and needed to be replaced; three bedside tables had sharp/rough edges; two rooms had sinks that were loose from the wall; three resident rooms had linoleum that was chipped/cracked and had sharp edges; five resident rooms had holes or chipped/cracked wallboard; three resident rooms had baseboards that were coming off the wall at the corners leaving sharp edges; two resident rooms had footboards that were rough with sharp edges; one resident room had a rough sharp edge on the resident's door; one torn chair cushion was observed in the dining room; and one resident room had the seal missing around the air-conditioner, leaving an open area to the outside of the facility. The findings include: An environmental tour of the facility revealed the following observations: Observations of the shower rooms on April 5 and 6, 2011, at 1:00 p.m. and 9:00 a.m., revealed the A Hall to have one shower chair with worn/frayed, sharp edges, and a shower lounge chair that was soiled and noted to have brown stains. In addition the B Hall shower had two shower chairs with worn/frayed sharp edges, a whirlpool bath with rubber molding that had rough edges, and a black mold-like substance on the grout around	F 253	Rooms 104-1, 117-1 and 113 bedside tables-Ordered new on 4-8-11; 4-29-11 the tables are expected to arrive. Rooms 106-1 footboard – Repaired on 4-8-11. Rooms 104 and 108 sinks-Repaired on 4-8-11. Room 208-1 had wallboard Repaired on 4-7-11 and rooms 107-1 and 216-4 hole-Repaired on 4-7-11 Rooms 115-2, 122-2, baseboards-Replaced on 4-8-11 Room 214-2 had air-conditioner unit-Repaired on 4-7-11 Room 216 air-conditioner unit.-Sealed and painted on 4-7-11 The main dining room had a chair with a rip in the cushion in need of replacing. -Discarded and replaced on 4-7-11 Mold like substance in the central baths removed with appropriate chemicals on 4-13-11 and 4-20 and are to be painted on 4-29-11.	

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F 253	Continued From page 10 the baseboards and the floor tiles in the shower stall. Observations during the environmental tour on April 6, 2011, at 9:00 a.m., revealed nine wheelchairs with cracked and peeling armrests (resident #3 and eight unsampled residents). Continued observations on April 6, 2011, at 9:00 a.m., revealed: -Rooms 104-1, 117-1, and 113-2 had bedside tables with rough edges. -Room 106-1 had a bed with a footboard that had rough edges. -Rooms 104 and 108 had sinks that were loose from the wall. -Room 208-1 had wallboard that was chipped, and rooms 107-1 and 216-4 had a hole in the wall. -Rooms 115-2, 122-2, and 214-2 had baseboards that were coming off the wall and had sharp edges. -Room 214-2 had a gap to the outside of the building around the air-conditioner unit. -Room 216 had a cracked area in the plaster above the air-conditioner unit. -The main dining room had a chair with a rip in the cushion in need of replacing. -Room 116 had a chipped, rough door with sharp	F 253	*How will the facility identify other residents having the potential to be affected by the same deficient practice?* A complete tour of the building was conducted on 4-27-11 preformed by the Administrator and Housekeeping Supervisor to insure compliance has been met. *What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?* An in-service regarding cleaning shower rooms with appropriate chemicals with house keeping staff was held on 4-25-11 which was conducted by the Maintenance Director. Environmental rounds shall be preformed by the Administrator, or designee, to check that maintenance services ensures this facility maintains a sanitary, orderly and comfortable interior. This will be done in addition to the rounds preformed by the Maintenance Director. Results of environmental rounds will be reported and recorded for the Safety Committee weekly review.	

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	185220	A. BUILDING _____ B. WING _____	C 04/06/2011

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

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F 253	Continued From page 11 edges. An interview with the Maintenance Supervisor (MS) on April 6, 2011, at 9:30 a.m., revealed staff was required to notify the MS of any needed repairs by documenting the repairs on forms located at the two nursing stations and the Therapy Departments. The MS further stated most residents would tell the MS what needed to be repaired. The MS further stated that an environmental four was conducted on a daily basis by the MS to observe for areas that needed repairs. The MS stated preventative maintenance was performed on all equipment and water temperatures were taken daily. An interview with the Housekeeping Supervisor on April 6, 2011, revealed the shower stalls should have been cleaned and did not know why the mold-like substance was present in both the A and B Wing shower rooms.	F 253	***How will the facility monitor its performance to ensure that solutions are sustained?*** The Safety Committee will continue to meet weekly for 1 year in or to ensure compliance has been meet. After a period of 1 year the Quality Assurance team will assess the need for the Safety Committee to meet weekly. As a part of Quality Assurance minutes from the safety committee will be reviewed monthly, for 1 year to ensure compliance has been met. After a period of 1 year the Quality Assurance team will assess the need to review the Safety Committee minutes monthly.	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	F 279 This facility will use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. This facility will develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	5-12-11

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F 279	Continued From page 12 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop care plan interventions to address the reoccurrence of skin tears for two of nineteen sampled residents. Residents #1 and #4 were identified with reoccurring skin tears; however, the facility failed to evaluate the effectiveness of current interventions and failed to develop interventions to prevent skin tears from reoccurring for residents #1 and #4. The findings include: 1. Resident #4 was admitted to the facility on December 20, 2010. The resident's diagnoses included lower extremity deep vein thrombosis, Stage IV decubitus on the right ischium and left foot, and Alzheimer's disease. Observation of resident #4 was conducted on April 5, 2011, at 9:30 a.m. The resident's right upper arm was observed to have a skin tear with bruising noted around the site. The skin tear was covered with a clear dressing. The lower right arm was observed to have a large uncovered purple bruise. In addition, the resident was observed to have a bruised area on his/her upper chest.	F 279	The care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under 483.25; and any services what would otherwise be required under 483.25 but are not provided due to the resident's exercise of rights under 483.10 including the right to refuse treatment under 483.10 (b) (4), evidenced by: ***What corrective action will be accomplished for those resident found to be affected by the deficient practice?*** Residents #1 and #4 have separate care plans specific for skin tears initiated on 4-6-11 with resident specific, resident appropriate interventions for the prevention of further skin tears. ***How will the facility identify other residents having the potential to be affected by the same deficient practice?*** All residents will receive a head-to-toe skin assessment. These assessments will be completed no later than 5-5-11. The Safety Committee will review upon completion. All findings will be recorded, tracked, treated and updates made to the care plan as needed.	

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F 279	Continued From page 13 A review of the Nurse's Notes/Physician's Orders for resident #4 revealed the resident was observed to have skin tears on January 4 and 19, 2011, February 8, 15, 18, and 19, 2011, and March 3, 2011. A review of the resident's care plan, dated January 3, 2011, revealed the resident was prone to skin tears due to his/her fragile skin. The intervention listed on the care plan dated January 3, 2011, was to use caution with resident transfers. There were no interventions identified related to skin tears/bruises the resident had sustained on or after January 3, 2011. An interview was conducted with the facility MDS Coordinator on April 5, 2011, at 10:30 a.m. The MDS Coordinator was unsure how the skin tear and bruising had occurred. The MDS Coordinator further stated the skin tear/bruising had not been investigated at the time of the occurrence nor had new interventions been care planned to prevent future skin tears/bruising. An interview was conducted with the facility Director of Nursing (DON) on April 5, 2011, at 10:30 a.m. The DON stated the facility did not care plan skin tears/bruising after each occurrence, nor did the care planning committee evaluate the current skin tear/bruising interventions for effectiveness. An interview was conducted with the facility Administrator on April 5, 2011, at 10:00 a.m. The Administrator stated the skin tears were not considered to be an incident and the staff did not routinely care plan or evaluate existing interventions for effectiveness to prevent future	F 279	***What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?*** Each nursing staff member receives a resident care sheet at the onset of every shift. Resident care sheets are a reflection of the Resident Care Plan. All nursing staff have been educated as to the importance and need to follow the care plans/resident care sheets which are developed, and updated by the MDS office. On 12-7-10 the facility initiated a new policy and procedure regarding care plans. An in-service was held with all nursing staff individually by the administrator on the importance of following the care plans and resident care sheets. This policy and procedure was added to new staff orientation on 12-7-10. This policy remains in effect with a repeated in service to ensure compliance on 5-12-11, this in-service was provided by the Staff Development Coordinator. A new policy regarding skin impairment was adopted on 4-5-11 that addresses skin injury. It insures monitoring, tracks, and trends all skin impairment.	

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F 279	Continued From page 14 resident skin tears. 2. Resident #1 was observed on March 4, 2011, at 4:30 p.m., to be sitting in a wheelchair with a padded cushion on the resident's right side. The resident was observed to be leaning to the right side. Resident #1 was not interviewable due to cognitive impairment. A skin assessment conducted on April 6, 2011, at 1:25 p.m., revealed resident #1 had two open wounds to the left buttock/coccyx area. No other skin breakdown was observed. A review of the incident reports dated March 28, 2011, revealed resident #1 sustained a skin tear to the left lower extremity while being transferred from the wheelchair to the bed. The incident report noted the resident's physician was contacted for treatment orders to be provided to the skin tear. On April 2, 2011, resident #1 again sustained a skin tear to the left forearm area (measuring approximately 2 inches) when being assisted to dress by facility staff. A review of the incident report dated April 2, 2011, revealed a direct care staff person was dressing the resident and the staff person's thumb "shifted," causing a tear in the resident's skin. A review of the annual comprehensive assessment conducted on January 7, 2011, revealed resident #1 was assessed to require extensive assistance of two staff persons for transfers and dressing, and total assistance of two for bed mobility. A review of the comprehensive care plan dated January 8, 2011, revealed the facility addressed a problem related to impaired skin integrity for	F 279	An in-service was held on 4-7-11 regarding new Policy and Procedure of Skin Impairment, including assessment and reporting of skin tears. Included in this in-service was the abuse policy and procedure that includes immediate notification, and reporting. This in-service was conducted by the Administrator and Director of Nursing. Additional in-servicing on Abuse Policy and Procedure and Skin Impairment Policy and Procedure began on 4-26-11 and shall be completed no later than 5-5-11. This in-servicing has been/will be conducted by the Social Service Director and Staff Development Coordinator to insure compliance. ***How will the facility monitor its performance to ensure that solutions are sustained?*** The safety committee will meet weekly, for one year, in order to track and trend all skin impairments. Interventions will be activated and care planned/and the resident care sheets are updated as needed. After a period of 1 year the Quality Assurance team will meet to assess the need for the Safety Committee to meet weekly.	

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F 279	Continued From page 15 resident #1 related to a Stage II pressure ulcer of the coccyx, little mobility, incontinence, and recent weight loss. Interventions included to provide treatment as ordered, to keep skin clean and dry, to reposition every two hours, and to use caution with transfers. In addition, the comprehensive care plan indicated the resident required two staff for assistance. However, there was no evidence the facility had developed a plan of care with interventions to address the skin tear the resident sustained on March 28, 2011 and on April 2, 2011, to include interventions to prevent skin tears from reoccurring. An interview conducted with the MDS/Care Plan Coordinator (CPC) on April 6, 2011, at 3:35 p.m., revealed the facility reviewed the incident reports related to skin tears for resident #1 during the morning administrative meetings. The MDS/CPC stated the physician's order for the initial treatment of the resident's skin tear was considered the intervention and no further care plan had been developed to prevent skin tear reoccurrence.	F 279	The Quality Assurance team will review Safety Committees minutes monthly for a period of 1 year. After a period of 1 year the Quality Assurance team will assess the need to review the Safety Committees minutes to track and trend all skin impairments.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309	F 309 The facility will ensure that each resident must receive and we will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with comprehensive assessment and plan of care, as evidenced by: ***What corrective action will be accomplished for those resident found to be affected by the deficient practice?*** Resident #5 was immediately cared for after the Administrator was alerted to the resident's need. A skin assessment was done after the care was rendered on 4-4-11 with no skin impairment observed. On the following day, 4-5-11, another skin assessment was done with no skin impairment observed.	5-5-11

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F 309	Continued From page 16 Based on observation, interview, and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of nineteen sampled residents. Resident #5 was observed to be soiled with feces for two hours during the evening meal on April 4, 2011. In addition, resident #5 was assessed to require extensive assistance with eating; however, facility staff was observed to set up the resident's meal tray and leave the room without providing any assistance with feeding for the resident. The findings include: A review of Perineal Care Policy/Procedure (no date noted) revealed residents should receive peri care after each voiding or stool to prevent skin breakdown. A review of the medical record revealed resident #5 was admitted to the facility on June 29, 2007, with diagnoses to include Fracture of the left hip, Severe Dementia, Tardive Dyskinesia, Type II Diabetes Mellitus, and Parkinson's Disease. A review of the annual comprehensive assessment completed on October 25, 2010, revealed resident #5 was assessed to require extensive assistance of one staff person for eating and total assistance of two staff persons for toileting needs. The resident was also assessed to be frequently incontinent of bowel and bladder. A review of the comprehensive care plan dated October 23, 2010, revealed the facility had identified a concern related to resident #5's toileting needs. Interventions included providing	F 309	***How will the facility identify other residents having the potential to be affected by the same deficient practice?*** All residents who are incontinent of bladder and/or bowel, or have occasional incontinence have the potential to be affected. Each resident has a B/B assessment in their medical record and the results of this assessment is reflected in each resident's care plan. ***What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?*** A mandatory in-service was held on 4-7-11 presented by the Director of Nurses regarding the facility's policy for incontinent care. A follow up in-service is scheduled to occur on 5-5-11 to be presented by the Director of Nursing to ensure compliance. A new Quality Assurance monitoring tool was adopted on 4-27-11 that will equip the Nurse Supervisor a method to perform a random sampling of Nursing Assistants performance and prompt response to call lights, assisting with ADL including but not limited to appropriate incontinent care.	

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F 309	Continued From page 17 the resident with adult briefs, and checking the resident and providing incontinence care during each CNA round (every two hours) and as needed. In addition, the facility noted resident #5 required extensive assistance with meals most of the time, "but was capable of self feeding, just not willing." Interventions included providing tray setup at all meals, and to encourage and allow the resident to feed herself as much as possible before providing assistance. Observation of resident #5 on April 4, 2011, at 4:30 p.m., revealed the resident was lying on the bed, with an incontinence brief in place. The brief was observed to be soiled with feces and a feces odor was observed in the resident's room. Observation at 5:00 p.m., revealed the resident remained soiled with loose feces observed coming out of the incontinence brief onto the resident's incontinence pad and onto the sock of the resident's right foot. Observation at 5:20 p.m., revealed certified nursing assistant (CNA) #1 went into resident #5's room to provide care for the resident's roommate. However, the CNA failed to provide incontinence care for resident #5 at that time. At 5:25 p.m., certified medication aide (CMA) #3 was observed to also enter the resident's room and administer medications to resident #5's roommate. At 5:30 p.m., CNA #1 was observed to take resident #5's evening meal tray into the resident's room and set up the resident's tray. However, CNA #1 did not identify the feces odor in the resident's room and failed to provide incontinence care to the resident prior to serving the resident's meal. In addition, CNA #1 failed to offer/provide assistance to the resident for eating. At 5:45 p.m., resident #5 was observed to be yelling "nurse, nurse" from the	F 309	***How will the facility monitor its performance to ensure that solutions are sustained?*** Review quality assurance monitoring tools during the monthly quality assurance team meeting for a period of 1 year. After 1 year the Quality Assurance team will review the need to continue the audits.	

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F 309	Continued From page 18 resident's room, however, CNA #1 continued to pick up the evening meal trays from other residents' rooms and failed to respond to resident #5's call. Observations continued at 6:00 p.m., and revealed CNA #1 offered resident #5's roommate assistance with eating; however, the CNA did not offer to provide/encourage resident #5 to eat. Resident #5 remained soiled with feces. At 6:30 p.m., another CNA (CNA #2) was observed to provide incontinence care for resident #5 (approximately two hours later). A skin assessment was conducted at 6:35 p.m., and revealed mild blanchable redness to the resident's perineal area. No broken areas were noted. Interview with CNA # 1 on April 4, 2011, at 5:30 p.m., revealed CNA #1 had checked resident #5 at 3:30 p.m. for incontinence and the resident was clean and dry at that time. CNA #1 stated he/she was unaware resident #5 was soiled with feces when the resident's tray was set up for the evening meal. CNA #1 stated he/she could not detect the feces odor due to sinus problems. The CNA stated incontinence rounds were required to be made every two hours and as needed, including during meal times and as the resident requested. CNA #1 also stated incontinence care had not been provided for resident #5 at 5:30 p.m., because the Director of Nursing (DON) had instructed this CNA not to provide incontinence care until all meal trays were picked up. CNA #1 further stated incontinence care should have been provided prior to the tray setup. In addition, CNA #1 stated he/she was not aware the resident required extensive assistance with eating, and assistance was only provided for resident #5 when the resident requested help.	F 309		

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F 309	Continued From page 19 Interview conducted with CNA #2 on April 4, 2011, at 6:20 p.m., revealed resident #5 was only fed during the meal when the resident asked to be fed. During an interview with the unit manager, Registered Nurse (RN) # 1, on April 4, 2011, at 6:40 p.m., he/she stated that "spot checks" are done during meal times to ensure care needs are being provided. RN #1 stated, "I'm not normally here at supper time, I am just working late today, and the resident should have been provided peri care in a timely manner." During an interview with the Director of Nursing (DON) on April 4, 2011, at 7:00 p.m., the DON stated that she/he "made rounds during meal times, and relied on the floor nurses to ensure resident needs were being met during meal times." The DON stated the resident should have been provided peri/incontinence care in a timely manner.	F 309		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure residents received food that was palatable and at the	F 364	F 364 This facility will ensure that each resident receives and this facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature, as evidenced by: ***What corrective action will be accomplished for those resident found to be affected by the deficient practice?*** Resident was brought new tray immediately that was palatable and at the proper temperature. ***How will the facility identify other residents having the potential to be affected by the same deficient practice?*** All residents have the potential to be affected that receive a meal on the carry out cart.	5-5-11

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F 364	Continued From page 20 proper temperature. A test tray on the B Wing hallway of the evening meal on April 4, 2011, revealed milk that was at 51 degrees Fahrenheit and was warm to taste. The findings include: Observation of the evening meal on April 4, 2011, at 5:05 p.m., revealed resident meal trays were taken by kitchen staff from the kitchen and set out on the B Wing floor in an open tray rack. An announcement over the intercom at 5:05 p.m., alerted floor staff that the B Wing trays were on the floor. A second announcement by the kitchen staff at 5:15 p.m., was made to alert the B Wing staff the meal trays were on the B Wing and ready to be served. Two more trays were brought to the same tray cart at 5:17 p.m., by the kitchen staff for two residents that decided to eat their meals in their rooms instead of the dining room. Further observation revealed the Director of Nurses (DON) and the B Wing Supervisor began to deliver the meal trays to the residents on the B Wing at 5:20 p.m., 15 minutes after the meal cart had been delivered to the unit. The surveyor intercepted the last meal tray to be removed from the cart at 5:35 p.m., in order to determine temperatures of the food items. The meat loaf, broccoli, macaroni and cheese, and coffee were noted to be palatable. However, the temperature of the milk was noted to be 50 degrees Fahrenheit and was warm to taste. An interview with the Dietary Manager (DM) on April 4, 2011, revealed the acceptable temperature for milk was at or below 41 degrees Fahrenheit after the milk had been delivered to	F 364	***What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?*** An in-service with Dietary Staff and Nursing Staff regarding promptness of trays being passed in order to insure food temperatures was held on 4-27-11 presented by Royal Manor's Registered Dietician. Additional in-services will continue in order to insure compliance to be completed no later than 5-5-11. The dietician adopted a tool on 4-27-11 to assist in random temperature audits for the trays on the carts that will be done weekly for 3 months, and monthly there after. ***How will the facility monitor its performance to ensure that solutions are sustained?*** The Registered Dietician's weekly tray audits shall be reviewed during monthly Q.A. meetings for 3 months. The monthly tray audits will be monitored by Q.A. here after.	

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	185220	A. BUILDING _____ B. WING _____	C 04/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL MANOR	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 364	Continued From page 21 the unit.	F 364		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to prepare food under sanitary conditions. Staff was observed to drop a juice glass onto the floor, to pick the glass up from the floor with gloved hands, and proceed to pour juice without changing gloves and washing hands. In addition, the double oven underneath the range was in need of a thorough cleaning, the ice scoop holder in the dining room was observed to be uncovered, and the bottom of the container was soiled. The findings include: 1. Observation of the tray line was conducted at 11:30 a.m. on April 5, 2011. During the tray line observation, a dietary employee was observed wearing gloves while pouring juice. The employee dropped a juice glass to the floor. The employee reached to the floor to pick the glass	F 371	F 371 This facility will 1. Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and 2. Store, prepare, distribute and serve food under sanitary conditions, as evidenced by: ***What corrective action will be accomplished for those resident found to be affected by the deficient practice?*** 1. Employee educated immediately. 2. Ovens received Deep Cleaning on 4-25-11 3. New Ice Scoop container replaced on 4-27-11 ***How will the facility identify other residents having the potential to be affected by the same deficient practice?*** All residents had the potential to be affected.	4-27-11

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	185220	A. BUILDING _____ B. WING _____	C 04/06/2011

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

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F 371	Continued From page 22 up, and proceeded to pour juice into glasses without removing the gloves or to wash the hands. However, the surveyor intervened and the employee removed the soiled gloves, washed his/her hands, and continued to pour juice into the glasses. An interview was conducted with the dietary employee who dropped the glass onto the floor at 11:45 a.m. on April 5, 2011. The employee stated that he/she did not realize that the gloves should have been changed and the hands washed after picking an item up off of the floor. A review of facility requirements for dietary staff revealed staff was to use proper handwashing after picking up anything from the floor. A review of the dietary employee's orientation checklist revealed the orientation did not include proper handwashing within the sanitation procedures for dietary employees. 2. Observation of the double ovens underneath the range at 12:07 p.m. on April 5, 2011, and another observation at 4:10 p.m. on April 6, 2011, revealed the ovens were in need of a thorough cleaning. A heavy buildup of burned carbon was observed inside both ovens and around the inside edges of the ovens. Dietary staff stated the double ovens were to be cleaned weekly. Staff further stated the double ovens should have been cleaned on March 31, 2011. 3. Observations of the ice scoop container located in the dining room at 4:00 p.m. on April 4,	F 371	***What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?*** All dietary employees have received an in-service regarding handling food under sanitary conditions, proper handwashing and gloving. This in-service was held on 4-8-11 presented by the Dietary Manager. The Dietary Manager has adopted a new orientation sheet checklist that includes proper handwashing technique within the sanitation procedures for dietary employees. This checklist was put in place on 4-26-11. The oven was placed on a weekly deep cleaning schedule on 4-25-11. The Dietary Manager shall report to the Staff Development Coordinator weekly in regard to these newly adopted tools for compliance. The ice scoop and container will be cleaned daily by housekeeping staff and the task has been adopted by the Housekeeping Supervisor on 4-27-11 The housekeeping staff were in-serviced by the housekeeping Supervisor on 4-27-11 regarding the cleaning of the ice scoop.	

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	185220	A. BUILDING _____ B. WING _____	C 04/06/2011

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F 371	Continued From page 23 2011, at 12:07 p.m. on April 5, 2011, and at 3:35 p.m. on April 6, 2011, revealed the ice scoop container was uncovered and the bottom of the container was observed to be soiled. Dietary staff was observed at 4:00 p.m. on April 4, 2011, to fill two buckets with ice from the ice machine in the dining room and return to the kitchen with the ice. Dietary staff used the scoop from the uncovered and soiled ice scoop container to obtain the ice.	F 371	***How will the facility monitor its performance to ensure that solutions are sustained?*** The Dietary monitoring tool regarding kitchen and dining room cleanliness shall be assessed monthly by the Quality Assurance team, for one year. After one year the Quality Assurance team will review the need to continue monthly audits. All new hires in dietary to be reviewed by Q.A. Team for compliance, for one year. Dietary Manager and House Keeping Supervisor will monitor ice scoop cleanliness daily hereafter.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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.	F 441	F441 The facility will establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection, as evidenced by: ***What corrective action will be accomplished for those resident found to be affected by the deficient practice?*** 1. Change in the practice of clearing tray. 2. Nurse in-serviced as to proper clean dressing change technique immediately.	5-5-11

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F 441	Continued From page 24 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain an infection control program designed to prevent the spread of infection. During observation of the evening meal on April 4, 2011, facility staff was observed to touch the garbage can lids. The staff failed to wash their hands with soap/water to remove potentially hazardous contaminants on their hands that had been obtained from the garbage can lid. In addition, staff failed to use aseptic (clean) technique during a wound care dressing change performed on April 6, 2011, for resident #12. The findings include: A review of the undated Applying a Dry, Non-Sterile Dressing policy revealed that all dressing changes required a glove change between clean and dirty dressing changes. A review of the Handwashing policy (not dated) revealed facility staff was required to wash their	F 441	***How will the facility identify other residents having the potential to be affected by the same deficient practice?*** All residents had the potential to be affected by transmission of disease and infection because the aging process decreases the ability of immune system to protect the body from potential infection. This facilities population would all have the potential because of disease, health, age, and other contributing factors which all have the potential to decrease the bodies immune response. All nursing Staff were in serviced on proper clean dressing changes with return demonstrations by the Director of Nursing. This in service for all nursing staff was completed on 5-5-11. A trash receptacle with a foot pedestal was placed in the dining room to prevent possible contamination. The nurses were in-serviced to monitor Infection Control Procedures in the dining room on 4-7-11. A nurse is assigned to the dining room during meal service. Additionally the dietician observed the dining room 4-13-11 to ensure proper infection control procedures were being followed.	

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	185220	A. BUILDING _____ B. WING _____	C 04/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 25 hands after removal of gloves or other personal protective equipment. The policy noted facility staff was also required to perform handwashing before/after all invasive procedures and touching wounds, and after touching inanimate sources which are soiled with virulent contaminants. 1. During the evening meal in the resident dining room on April 4, 2011, at 5:30 p.m., Certified Nursing Assistants (CNAs) were observed to lift the soiled garbage can lids with their bare hands. The CNAs were observed to use an alcohol-based sanitizer after touching the soiled lids and proceeded to obtain meal trays from the Dietary Department, deliver the trays to the residents, and to assist residents with their meal trays. The CNAs were not observed to utilize soap/water located at the sink adjacent to the resident dining room to clean and remove soil/debris from their hands. An interview was conducted with the Staff Development Nurse on April 4, 2011, at 5:30 p.m. The Staff Development Nurse stated the staff had received training in-service numerous times on hand washing protocols. An interview conducted with the three CNAs passing trays on April 4, 2011, at 5:30 p.m., revealed the CNAs were aware they were required to cleanse their hands with soap/water after handling soiled material(s). 2. Observation of a dressing change for resident #4 on April 6, 2011, at 1:50 p.m., revealed LPN #1 washed his/her hands with soap and water, applied a pair of gloves, and then removed a dressing from the resident's left ankle. The	F 441	*What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?* An in-service regarding infection control and proper handwashing was held on 4-7-11 presented by the Director of Nurses. According to Mosby's textbook for Long-Term Care Nusing Assistants 5th addition, "Handwashing is the is the easiest and most important way to prevent the spread of infection." (pg. 181). An in-service was presented by the Director of Nurses for the Licensed Nursing Staff specifically in regard to the proper wound care technique including handwashing, aseptic technique and dressing change on 4-7-11. The Staff Development Coordinator has adopted a method to ensure that all nursing staff shall be proficient in performing the skills of handwashing, aseptic technique, wound care and dressing change annually on the anniversary of their date of hire. This method of education was adopted on 4-26-11 to ensure compliance. The dietary staff will be monitored by dietician weekly for proper infection control procedure.	

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

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F 441	Continued From page 26 dressing was observed to have a small to moderate amount of brown-colored drainage from a Stage III decubitus ulcer located on the outer aspect of the resident's left ankle. LPN #1 did not remove the soiled gloves and proceeded to cleanse, apply ointment to, and re-wrap the decubitus ulcer while wearing the soiled gloves. LPN #1 removed the soiled gloves, washed his/her hands with soap and water, and removed a dressing from the resident's right upper hip area revealing a Stage III decubitus ulcer. There was no drainage noted from the right hip wound dressing. LPN #1 did not remove the soiled gloves and proceeded to clean, pack, and redress the decubitus on the resident's right upper hip area. LPN #1 then removed the soiled gloves and washed his/her hands with soap and water. Interview with LPN #1 on April 6, 2011, at 2:15 p.m., revealed LPN #1 was aware of the facility's policy to remove gloves after removing the soiled dressings, and to wash his/her hands and to apply clean gloves prior to performing any cleansing, application of ointments to, or redressing of decubitus ulcers. LPN #1 stated he/she forgot to change the soiled gloves and wash his/her hands when he/she performed the resident's wound care. Interview with the Director of Nursing on April 6, 2011, at 4:30 p.m., revealed nurses were required to change gloves between dirty and clean dressing changes and to wash hands with soap and water as required by facility policy.	F 441	***How will the facility monitor its performance to ensure that solutions are sustained?*** Random sampling of Nursing Demonstration Monthly and reviewed during quality assurance for a period of one year to ensure compliance. After one year the quality assurance team will assess the need to continue reviewing the random sampling of nursing demonstrations. Dietician report to be monitored during quality assurance for a period of one year to ensure compliance. After one year the quality assurance team will assess the need to continue reviewing the Dietacian's report.	
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM	F 469	F 469 This facility will maintain an effective pest control program so that the facility is free of pests and rodents. ***What corrective action will be accomplished for those resident found to be affected by the deficient practice?*** Orkin notified and came to the facility on 4-5-11 Maintenance and Housekeeping notified immediately, and sprayed immediately for ants. The area was cleaned of food particles on 4-5-11.	4-27-11

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F 469	Continued From page 27 The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain an effective pest control program. Live ants were observed on April 4-6, 2011, in the facility dining room and in resident room 212. The findings include: Observation of the dining room during the meal service on April 4, 2011, at 5:50 p.m. revealed black ants (too numerous to count) on a food particle on the floor in the main resident dining room. Observation of the dining room on April 5, 2011, at 11:15 a.m., and on April 6, 2011, at 9:30 a.m., revealed black ants (too numerous to count) on the floor under the ice machines. Observation on April 6, 2011, at 8:50 a.m., revealed black ants on the sink in resident room 212. Facility staff was notified of ants in the resident room at 8:50 a.m., by the surveyor. Interview with the Housekeeping Supervisor and the Administrator on April 4, 2011, at 6:00 p.m., revealed facility staff had identified a problem with ants in the facility and had previously contacted a pest control company. The Administrator stated	F 469	***How will the facility identify other residents having the potential to be affected by the same deficient practice?*** All residents have the potential to be affected by the deficient practice. A 100% audit of the entire building was conducted by housekeeping staff on 4-26-11 to ensure the building was pest free. Orkin also came on 4-27-11. ***What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?*** Royal Manor Currently has a contract with Orkin Pest Control. We had the contract prior to state survey. After consulting with our Orkin representative on 4-26-11 he advised that this was the time of year that ants come out of hibernation, and Royal wasn't necessarily doing anything wrong. That the extreme wet spring that central Kentucky has seen an increase in ants with the buildings that Orkin Services. We will continue to utilize Orkin, and notify Orkin upon any and all signs of pest in the facility.	

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F 469	Continued From page 28 the maintenance staff and the pest control company had treated the facility for ants; however, ants continued to be a problem at the facility. Interviews with the Maintenance Supervisor (MS) and the Housekeeping Supervisor (HKS) on April 6, 2011, at 9:30 a.m., revealed ants had been an ongoing problem at the facility even though the pest control company had sprayed the outside grounds and the inside hallways of the facility on numerous occasions with insecticide.	F 469	Environmental rounds to be preformed weekly by Administrator or designee to check for environmental hazards such as pest. A monitoring checksheet has been adopted on 4-27-11. This new policy is in addition to the rounds preformed by the Maintenance Director. The Administrator or designee will report to the Safety committee for weekly review. The Quality Assurance team will add a section in the admission packet requiring that all food brought in must be placed in sealed containers on 4-26-11. A letter was sent 4-27-11 to inform all residents families that any food brought into the facility must be in sealed containers ***How will the facility monitor its performance to ensure that solutions are sustained?*** Minutes from the safety committee will be reviewed during quality assurance, for one year. After one year the Quality Assurance team will assess the need to continue to monitor the weekly safety committee minutes.	

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Division of Health Care
Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185220	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS TYPE OF STRUCTURE: 1975 One-story unprotected frame Type 111(200) with a complete automatic sprinkler system throughout. A life safety code survey was initiated and concluded on April 5, 2011. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). Royal Manor was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level.	K 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. This document is not intended to waive any defense, legal or equitable, in administrative civil, or criminal proceedings.	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	K 018 This facility will ensure doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable or resisting fire for at least 20 minutes. Door in sprinklered building are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed.	4-27-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Benjamin J. Sparkes	Administrator	4-29-11

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

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	185220	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/05/2011

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ROYAL MANOR	100 SPARKS AVENUE NICHOLASVILLE, KY 40356

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor doors were maintained according to NFPA standards. This deficient practice affected three of four smoke compartments, staff, and approximately 50 residents. The facility has the capacity for 83 beds with a census of 78 on the day of the survey. The findings include: During the Life Safety Code tour on April 5, 2011, from 9:55 a.m. to 12:00 p.m., with the Director of Maintenance (DOM), drop-down hold-open devices were observed holding doors open to the kitchen and three resident room corridor doors. According to regulations this type of hold-open device is not an approved device to hold corridor doors open. An interview on April 5, 2011, at 9:55 a.m., with the DOM revealed the DOM was not aware that the hold-open devices should not be used to hold corridor doors open. Reference: NFPA 101 (2000 Edition). 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that	K 018	Roller latches are prohibited by CMS regulations in all health care facilities, as evidenced by: ***What corrective action will be accomplished for those resident found to be affected by the deficient practice?*** All drop-down hold-open devices were removed prior to the end of survey, on 4-6-11. ***How will the facility identify other residents having the potential to be affected by the same deficient practice?*** All residents had the potential to be affected. ***What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?*** Environmental rounds to be preformed weekly by Administrator or designee to check for environmental hazards such as door stops. A monitoring checksheet has been adopted on 4-27-11. This new policy is in addition to the rounds preformed by the Maintenance Director.	

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K 018	Continued From page 2 necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches 19.3.6.3.4 Door-closing devices shall not be required on doors in corridor wall openings other than those serving required exits, smoke barriers, or enclosures of vertical openings and hazardous areas.	K 018	The Administrator or designee will report to the Safety committee for weekly review. ***How will the facility monitor its performance to ensure that solutions are sustained?*** Minutes from safety committee meeting to be reviewed monthly during the quality assurance team meeting.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that a corridor door to a hazardous area was held open in an approved manner. This deficient practice affected one of four smoke compartments, staff, and approximately 10 residents. The facility has the capacity for 83 beds with a census of 78 on the day of the survey.	K 029	K 029 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, as evidenced by: ***What corrective action will be accomplished for those resident found to be affected by the deficient practice?***	4-27-11

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K 029	Continued From page 3 The findings include: During the Life Safety Code tour on April 5, 2011, at 10:15 a.m., with the Director of Maintenance (DOM), a corridor door leading to the laundry room was observed to have a drop-down hold-open device attached to the lower portion of the door. Doors to hazardous areas are not allowed to be held open in this manner. An interview with the DOM on April 5, 2011, at 10:15 a.m., revealed the DOM was not aware this was an unapproved device to hold the laundry door open. Reference: NFPA 101 (2000 Edition). 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be	K 029	The laundry room door and all doors to hazardous areas remain closed at all times when not in use to insure that smoke compartments are maintained. ***How will the facility identify other residents having the potential to be affected by the same deficient practice?*** All residents have the potential to be affected ***What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?*** In-service to all dietary and house keeping staff that the doors need to stay closed was held on 4-27-11 presented by the Administrator. Environmental rounds to be preformed weekly by Administrator or designee to check for environmental hazards such as doors opened to hazardous areas. A monitoring checksheet has been adopted on 4-27-11.	

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

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K 029	Continued From page 4 readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 029	This new policy is in addition to the rounds preformed by the Maintenance Director. The Administrator or designee will report to the Safety committee for weekly review. ***How will the facility monitor its performance to ensure that solutions are sustained?*** Minutes from the safety committee to be reviewed monthly by the quality assurance team.	
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to have a written plan in place for evacuation of the building's smoke compartments directly affected by fire. This deficient practice affected four of four smoke compartments, staff, and all of the residents. The facility has the capacity for 83 beds with a census of 78 on the day of the survey. The findings include: During a records review on April 5, 2011, at 12:10 p.m., an interview with the Director of Maintenance revealed the facility had in place a fire plan to isolate residents in their rooms and for total evacuation of the building in case of fire; however, there was no policy on evacuating	K 048	K 048 There is a written plan for the protection of all patients and for their evacuation in the event of an emergency, as evidenced by: ***What corrective action will be accomplished for those resident found to be affected by the deficient practice?*** Change the Fire policy/procedure to include a plan for evacuating residents from one corridor to another began on 4-27-11.	5-5-11

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K 048	Continued From page 5 residents from one smoke compartment to another smoke compartment within the facility as required. Reference: NFPA 101 (2000 Edition). 19.1.1.3 Total Concept. All health care facilities shall be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. Because the safety of health care occupants cannot be ensured adequately by dependence on evacuation of the building, their protection from fire shall be provided by appropriate arrangement of facilities, adequate staffing, and development of operating and maintenance procedures composed of the following: (1) Design, construction, and compartmentation (2) Provision for detection, alarm, and extinguishment (3) Fire prevention and the planning, training, and drilling programs for the isolation of fire, transfer of occupants to areas of refuge, or evacuation of the building 19.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy's fire safety plan.	K 048	***How will the facility identify other residents having the potential to be affected by the same deficient practice?*** All residents have the potential to be affected. ***What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?*** In-service for all staff was held on 4-27-11 and will be completed no later than5-5-11 regarding new policy/procedure for evacuating residents from one corridor to another. A fire drill will be preformed at least monthly. ***How will the facility monitor its performance to ensure that solutions are sustained?*** Entire Fire policy to be reviewed after fire drills which are held at least monthly. Monitored through Quality Assurance Team meetings monthly.	

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K 048	Continued From page 6 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire	K 048		
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 074	K 074 This facility will ensure that draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films services as furnishing or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2(2) and 10.3.3 19.7.5, NFPA 13	4-29-11

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K 074	Continued From page 7 failed to ensure that window curtains had documentation showing a fire-resistant rating as required by NFPA standards. This deficient practice affected one of four smoke compartments, staff, and approximately 14 residents. The facility has the capacity for 83 beds with a census of 78 on the day of the survey. The findings include: During the Life Safety Code tour on April 5, 2011, at 11:00 a.m., with the Director of Maintenance (DOM), window curtains located in the front lobby were noted not to have a label indicating they were flame-resistant. An interview with the DOM on April 5, 2011, at 11:00 a.m., revealed the DOM was not aware that curtains should have documentation to show these curtains were flame-resistant. Reference: NFPA 101 (2000 Edition). 19.7.5.1* Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies shall be in accordance with the provisions of 10.3.1. (See 19.3.5.5.) Exception: Curtains at showers. 10.3.6 Fire-retardant coatings shall be maintained to retain the effectiveness of the treatment under service conditions encountered in actual use. 10.3.1* Where required by the applicable provisions of this Code, draperies, curtains, and other similar	K 074	Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3), 10.3.4. 19.7.5.3, as evidenced by: ***What corrective action will be accomplished for those resident found to be affected by the deficient practice?*** Fire retardant treatment applied to on front lobby curtains on 4-29-11. ***How will the facility identify other residents having the potential to be affected by the same deficient practice?*** All residents have the potential to be affected. ***What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?*** An audit of all curtains was completed on 4-29-11 by the Maintenance Director to ensure compliance ***How will the facility monitor its performance to ensure that solutions are sustained?***	

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K 074	Continued From page 8 loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.	K 074	The quality assurance team will approve all future purchases of curtains in order to insure they are fire retardant.	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical needs of the facility met NFPA standards. This deficient practice affected four of four smoke compartments, staff, and all the residents. The facility has the capacity for 83 beds with a census of 78 on the day of the survey. The findings include: A review of the facility's compliance history revealed the facility was cited for the same deficient practice on April 27, 2010. Resident room 216 was also cited on this survey as well. According to the facility's plan of correction effective May 28, 2010, the facility would in-service staff and complete an audit of all resident rooms to ensure medical equipment would be plugged into a proper power source. The facility was also provided with other electrical regulatory requirements pertaining to extension cords and multi-outlet adapters in the deficiency statement.	K 147	K 147 This facility will ensure electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2, as evidenced by: ***What corrective action will be accomplished for those resident found to be affected by the deficient practice?*** Power strips removed immediately. Hardwired electrical outlets were installed on 4-28-11 in rooms that are identified in the Statement of Deficiencies.	4-28-11

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K 147	Continued From page 9 During the Life Safety Code tour on April 5, 2011, from 9:45 a.m. to 12:00 p.m., with the Director of Maintenance (DOM), an electric bed cord was observed to be plugged into a multi-outlet adapter (power strip) in resident room 216. Generally power strips with surge protection may be used for resident TVs, computers, radios, etc., on an as-needed basis but are not to be used with medical equipment to help prevent against electrical shock. An extension cord was also noted to be in use in this resident room. Extension cords and power strips are not a substitute for an area that needs permanent wiring. Multi-outlet adapters with long cords were observed throughout the facility. In addition an electrical power cord in resident room 103 was observed to pass under a closet door through the closet wall to access an area that needed an electrical supply. An interview with the DOM on April 5, 2011, at 9:45 a.m., revealed the DOM was not aware this was an unsafe practice. The DOM stated there were not enough proper receptacles in the building. Reference: NFPA 99 (1999 Edition). 3-3.2.1.2 D 2. Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. Reference: NFPA 70 (1999 Edition). 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7,	K 147	***How will the facility identify other residents having the potential to be affected by the same deficient practice?*** All residents have the potential to be affected. ***What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?*** Environmental rounds to be preformed weekly by administrator or designee to check for environmental hazards such as power strips. This will be done in addition to the rounds preformed by the Maintenance Director. The administrator will turn a monitoring sheet with results of rounds will be turned into the Safety committee for weekly review. ***How will the facility monitor its performance to ensure that solutions are sustained?*** The minutes of the safety committee will be reviewed monthly during the quality assurance team meeting.	

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K 147	Continued From page 10 flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a structure 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: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code.	K 147		
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop a fire watch policy to ensure the safety of occupants of the building in case of automatic sprinkler system failure. This deficient practice affected four of four smoke	K 154	K 154 This facility will ensure that where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service 9.7.6.1, as evidenced by: ***What corrective action will be accomplished for those***	5-5-11

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K 154	Continued From page 11 compartments, staff, and all of the residents. The facility has the capacity for 83 beds with a census of 78 on the day of the survey. The findings include: During the life safety code tour on April 5, 2011, at 12:05 p.m., an interview with the Director of Maintenance (DOM) revealed the DOM was not aware the facility was required to have a fire watch policy in place in the event the building's automatic sprinkler system failed. The DOM stated the DOM had access to life safety code requirements but was not very familiar with the requirements.	K 154	***resident found to be affected by the deficient practice?*** A Fire Watch policy and procedure was added to the fire policy on 4-27-11. ***How will the facility identify other residents having the potential to be affected by the same deficient practice?*** All residents have the potential to be affected.	
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop a fire watch policy to ensure the safety of occupants of the building in case of fire alarm failure. This deficient practice affected four of four smoke compartments, staff, and all of the residents. The facility has the capacity for 83 beds with a census of 78 on the day of the survey. The findings include:	K 155	K 155 This facility will ensure that where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service 9.6.1.8, as evidenced by: ***What corrective action will be accomplished for those resident found to be affected by the deficient practice?***	5-5-11

K 154

What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?

All staff to be in-serviced regarding Fire Policy starting on 4-27-11 to be completed 5-5-11 by the Maintenance Director.

How will the facility monitor its performance to ensure that solutions are sustained?

Entire Fire policy to be reviewed after fire drills which are held at least monthly. Monitored through Quality Assurance Team meetings monthly.

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K 154	Continued From page 11 compartments, staff, and all of the residents. The facility has the capacity for 83 beds with a census of 78 on the day of the survey. The findings include: During the life safety code tour on April 5, 2011, at 12:05 p.m., an interview with the Director of Maintenance (DOM) revealed the DOM was not aware the facility was required to have a fire watch policy in place in the event the building's automatic sprinkler system failed. The DOM stated the DOM had access to life safety code requirements but was not very familiar with the requirements.	K 154	***resident found to be affected by the deficient practice?*** A Fire Watch policy and procedure was added to the fire policy on 4-27-11. ***How will the facility identify other residents having the potential to be affected by the same deficient practice?*** All residents have the potential to be affected.	
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop a fire watch policy to ensure the safety of occupants of the building in case of fire alarm failure. This deficient practice affected four of four smoke compartments, staff, and all of the residents. The facility has the capacity for 83 beds with a census of 78 on the day of the survey. The findings include:	K 155	K 155 This facility will ensure that where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service 9.6.1.8, as evidenced by: ***What corrective action will be accomplished for those resident found to be affected by the deficient practice?***	5-5-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185220	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL MANOR	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 155	Continued From page 12 During the life safety code tour on April 5, 2011, at 12:05 p.m., an interview with the Director of Maintenance (DOM) revealed the DOM was not aware the facility was required to have a fire watch policy in place in the event the building's fire alarm system failed. The DOM stated the DOM had access to life safety code requirements but was not very familiar with the requirements.	K 155	Fire watch policy and procedure to be added to the fire policy when the sprinkler system is out of service for more than 4 hours. Completed on 4-27-11. ***How will the facility identify other residents having the potential to be affected by the same deficient practice?*** All residents had the potential to be affected. ***What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?*** All staff to be in-serviced regarding Fire Policy starting on 4-27-11 to be completed 5-5-11 by the Maintenance Director. ***How will the facility monitor its performance to ensure that solutions are sustained?*** Entire Fire policy to be reviewed after fire drills which are held at least monthly. Monitored through Quality Assurance Team meetings monthly.	