

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

PRINTED: 05/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/29/2010
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey and an Abbreviated Survey investigating ARO# KY00014695 and ARO# KY00014696 was conducted 04/27/10 through 04/29/10. A Life Safety Code Survey was conducted 04/27/10. Deficiencies were cited with the highest scope and severity of a "F". ARO# KY00014695 and ARO# KY00014696 were unsubstantiated.	F 000	Preparation and/or execution of this 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 not intended to waive any defense, legal or equitable, in administrative, civil, or criminal proceedings.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure physician orders were followed for one (1) of fifteen (15) sampled residents (Resident #5). Resident #5 had an order for TED hose to be applied to the right lower extremity. However, observation revealed the TED hose was not applied as ordered. The findings include: Record of Resident #5's clinical record revealed diagnoses which included Difficulty in Walking, Gout, Osteoarthritis, Chronic Lower Back Pain, and Alzheimers Disease. Review of the Resident #5's most recent MDS (Minimum Data Set), a Quarterly assessment completed on 03/03/10 revealed the facility assessed the resident as having long and short-term memory deficits and mildly-impaired cognitive skills. The facility assessed the resident required extensive to total	F 281	RECEIVED JUN - 7 2010 BY: _____ The facility will ensure that services provided or arranged by the facility meet professional standards of quality specifically to the application of the TED hose. <u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> Resident #5 had a new pair of TED hose ordered on 4/29/2010. The pharmacy received and filled the order on 4/29/2010. The TED hose was applied as ordered. *Please note that the date cited in the SOD should have been 4/29/2010 as to when the DON was made aware and when the TED was ordered from the pharmacy rather than 4/28/2010. J.Aikens with OIG made aware of this typo and advised reference.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Benjamin J. Sparks</i>	TITLE Administrator	(X6) DATE 5-21-10
--	------------------------	----------------------

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

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

PRINTED: 05/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/29/2010
NAME OF PROVIDER OR SUPPLIER ROYAL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	<p>Continued From page 1</p> <p>assistance with all ADLs (Activities of Daily Living). The facility noted the resident had limited ROM of one foot and partial loss of voluntary movement.</p> <p>Review of Resident #5's medical record revealed that, on 02/26/10, the Physician had ordered the resident to wear a TED Hose to be applied to the right lower extremity each morning, and to be removed bedtime. Review of the Comprehensive Plan of Care revealed an intervention related to the use of the TED Hose as related to previous DVT (Deep Vein Thrombosis) involving the right leg.</p> <p>On 04/28/10 at 10:15 AM, LPN #3 was observed to perform a skin assessment on Resident #5 which revealed the resident did not have the TED Hose applied, as ordered by the Physician. During the observation edema was noted to be present in the resident's right lower extremity. The resident was observed throughout the remainder of the survey to be setting up in a wheelchair. On 04/28/10 at 3:00 PM, the resident was again observed to not have the TED hose on as ordered. A similar observation was made on 04/29/10 at 10:20 AM. In both cases, observation revealed edema in the resident's lower extremities.</p> <p>At 12:00 AM on 04/28/10, LPN #3 was interviewed and stated "We noticed the hose were missing on the previous day and, this morning, one of the aides noted them missing as well. We searched the laundry, but could not find them".</p> <p>Interview with the Director of Nursing (DON) on 04/28/10 revealed he had observed the absence</p>	F 281	<p><u>How will the facility identify other residents have the potential to be affected by the same deficient practice?</u></p> <p>Specially to TED hose, all resident wearing TED hose were reviewed to ensure that each resident with orders to wear the TED hose had them readily available for application on 5/3/2010 by the Director of Nursing. A one time 100% audit of physician orders were reviewed by DON and MDS Coordinator 5/19/10 to ensure that items specific to resident care was readily available for use.</p> <p><u>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur?</u></p> <p>Nursing staff was in-serviced by the Staff Development Coordinator on 5/6/2010 regarding using the CNA care sheets to identify items for use according to physician orders. Further training by the DON and SDC regarding how to obtain items needed for resident care was held on 5/20/2010. Care items, specifically TED hose, were ordered and a par level will be readily available. This is a system change to ensure availability of such care items.</p>		

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

PRINTED: 05/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/29/2010
NAME OF PROVIDER OR SUPPLIER ROYAL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 281	Continued From page 2 of the resident's TED Hose after visually checking the resident. At 10:25 AM, the DON notified the surveyor that staff had discovered on the previous day that the resident's TED Hose was missing and the hose would be reordered later that afternoon, which should be delivered later that evening.	F 281	<u>How will the facility monitor its performance to ensure that solutions are sustained?</u> From the one time physician order audit, the CNA care sheets were updated to include specific items for care to ensure application. A review of the care sheets will be done at least once daily by a licensed nurse to ensure that physician order item specific are available for use and in use as ordered. These reviews will be turned into the DON for a period of three months or until substantial compliance is met. Findings will then be presented to the Quality Assurance Team for review and comment to ensure continued compliance.	5/28/2010
F 282 SS=D	483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the Plan of Care was implemented one (1) of fifteen (15) sampled residents (Resident #5). Resident #5 Comprehensive Plan of Care indicated the resident was to have TED Hose applied related to previous DVT (Deep Vein Thrombosis) involving the resident's right leg. The findings include: Review of Resident #5's clinical record revealed diagnoses which included Difficulty in Walking, Gout, Osteoarthritis, Deep Vein Thrombosis and Alzheimer's Disease. Review of the resident's most recent MDS (Minimum Data Set), a quarterly assessment completed on 03/03/10 revealed the facility assessed the resident as having long and short-term memory deficit with mildly-impaired cognitive skills and extensive to total assistance with all ADLs (Activities of Daily	F 282	The facility will ensure that services provided or arranged by the facility be provided by qualified persons in accordance with the resident's written plan of care. <u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> Resident #5 had a new pair of TED hose ordered on 4/29/2010. The pharmacy received and filled the order on 4/29/2010. The TED hose was applied as ordered. *Please note that the date cited in the SOD should have been 4/29/2010 as to when the DON was made aware and when the TED was ordered from the pharmacy rather than 4/28/2010. J.Aikens with OIG made aware of this typo and advised reference.	

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

PRINTED: 05/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/29/2010
NAME OF PROVIDER OR SUPPLIER ROYAL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 3 Living).</p> <p>Further review of Resident #5's clinical record revealed a Physician's order, dated 02/26/10 for the resident to wear a TED hose to be applied to the right lower extremity each morning, and to be removed at each bedtime.</p> <p>Review of the Comprehensive Plan of Care review revealed the resident's Care Plan had noted the use of the TED Hose and noted the hose was used as a result of a previous DVT (Deep Vein Thrombosis) involving the resident's right leg.</p> <p>On 04/28/10 at 10:15 AM, LPN #3 was observed to perform a skin assessment on Resident #5 which revealed the TED Hose was not applied, per the Plan of Care. Edema was noted to be present in the resident's right lower extremity.</p> <p>On 04/28/10 at 3:00 PM, the resident was observed to not have the TED Hose applied, to the left lower extremity. Observation on 04/29/10 at 10:20 AM revealed the TED Hose was not applied. In both cases, observation revealed Resident #5 left lower extremity continued to have edema. The resident was observed several times during the survey to be settling up in his/her wheelchair.</p> <p>On 04/28/10 at 12:00 PM interview with LPN #3 revealed "We noticed the hose missing on the previous day and, this morning, one of the aides noted them missing as well. We searched the laundry, but could not find them". LPN #3 indicated she was unaware if hose had been reordered.</p>	F 282	<p><u>How will the facility identify other residents have the potential to be affected by the same deficient practice?</u></p> <p>Specially to TED hose, all resident wearing TED hose were reviewed to ensure that each resident with orders to wear the TED hose had them readily available for application on 5/3/2010 by the Director of Nursing. A one time 100% audit of physician orders were reviewed by DON, MDS Coordinator, and RN Supervisor on 5/19/10 to ensure that items specific to resident care was readily available for use was completed on 5/19/2010 and placed on the care plan as well as the CNA care sheet which is an extension of the care plan.</p> <p><u>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur?</u></p> <p>Nursing staff was in-serviced by the Staff Development Coordinator on 5/6/2010 regarding using the CNA care sheets to identify items for application according to physician orders. Further training by the DON and SDC regarding how to obtain items needs for resident care was held on 5/20/2010. Items, specifically TED hose, were ordered and a par level will be readily available. This is a system change to ensure availability of such care items are listed upon care plan and the CNA care sheet to ensure appropriate usage of care items.</p>		

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

PRINTED: 05/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/29/2010
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	Continued From page 4 During an interview with the Director of Nursing (DON), he visually checked the resident confirmed the resident did not have the TED Hose applied. Shortly thereafter (at 10:25 AM), the DON notified the surveyor staff had discovered on the previous day that the resident's TED Hose was missing and had reordered the TED Hose from Pharmacy, which should be delivered later that evening.	F 282	<u>How will the facility monitor its performance to ensure that solutions are sustained?</u> From the one physician audit, the CNA care sheets were updated to include specific items for care to ensure application. A 10% audit of the care plans/sheets will be done at least once daily by a licensed nurse to ensure item specific are available for use and in use as ordered. These audits will be turned into the DON for a period of three months or until substantial compliance is met. Findings will then be presented to the Quality Assurance Team for review and comment to ensure continued compliance.	5/28/2010
F 371 SS=E	483.35(j) 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 and interview, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observation during the initial tour of the kitchen revealed water dripping on food in the walk-in refrigerator, a pitcher of nectar thick tea dated 4/18 was observed in the walk-in refrigerator, two (2) oakes were observed in dry storage without labels or dates, and steam table pans and plate covers and bottoms were observed to be stored wet. In addition, a male employee was observed preparing food without a beard restraint.	F 371	<u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> No resident was specifically identified. <ul style="list-style-type: none"> The food where water was dripping was disposed of on 4/27/2010. The walk-in refrigerator was repaired on by a contracted refrigeration company on 4/27/2010. The nectar tea was disposed of on 4/27/2010. The two cakes were disposed of on 4/27/2010. 	

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

PRINTED: 05/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2010
NAME OF PROVIDER OR SUPPLIER ROYAL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40366	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 371	<p>Continued From page 5</p> <p>The findings include:</p> <p>Observation during the initial tour on 04/27/10 at 8:50 AM revealed water dripping from a cooling unit in the walk-in refrigerator. Water was noted to be puddled and splattered on tops of covered individual fruit bowls, as well as dripping on cabbage stored behind the tray of fruit bowls.</p> <p>Interview on 04/29/10 at 1:45 PM with the Dietary Manager revealed the cooling unit, which was dripping, was repaired on 04/27/10 sometime in the afternoon. She indicated she was unaware if the individual covered fruit bowls which had been dripped on were served to the residents, but stated "they shouldn't have been served with that water on them. They should have been disposed of."</p> <p>In addition, observation during the initial tour on 04/27/10 at 9:05 AM revealed nectar thick tea in a pitcher in the walk-in refrigerator labeled 4/18 (9 days earlier). Interview with the Dietary Manager on 04/29/10 at 1:45 PM revealed tea needs to be made fresh daily. She added staff cleans out the refrigerator daily, and they should have disposed of it.</p> <p>Observation during the initial tour revealed two (2) cakes in pans without labels or dates, in the canned goods storage area. Interview on 04/27/10 at 1:45 PM with the Dietary Manager revealed everything should be labeled and dated. In addition she stated, "The cake should have been in the refrigerator, and the facility's policy was not followed.</p> <p>Additional observation during the initial tour revealed thirty (30) plate covers and bottoms</p>	F 371	<ul style="list-style-type: none"> The wet items identified (plate lids & bottoms and steam table pans) were rewashed, rinsed and allowed to air dry on 4/27/2010. The dish washer was serviced on 5/7/2010 by contracted repair/service company. Beard restraints were ordered on 4/29/2010 after the item was made aware on 4/29/2010. Coincidentally all male employees purposely shaved removing all facial hair on 4/30/2010 to keep from wearing the beard restraints that were made available to them on 4/30/2010. <p><u>How will the facility identify other residents have the potential to be affected by the same deficient practice?</u></p> <p>All residents receiving food out of the kitchen has the potential of being affected by the deficiency.</p> <p><u>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur?</u></p> <p>Dietary staff was in-serviced by the contracted Registered Dietician on 5/12/2010 that included hair/beard restraints usage, food storage with particular detail to dating, labeling, and disposing of late dated items, dishware and cook ware washing, rinsing, air drying, and storage, inspection of appliances or equipments to ensure good working condition.</p>	

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

PRINTED: 05/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/29/2010
NAME OF PROVIDER OR SUPPLIER ROYAL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 371	Continued From page 6 stored wet, and seven (7) steam table pans stored wet. Interview on 04/27/10 at 9:33 AM with the Dietary Manager, revealed the items should not be stored wet. "They would be wet and nasty and grow bacteria". She stated they should have been air-dried before being stored. Further observation during tray line on 04/27/10 at 11:00 AM revealed a male dietary aide with a beard preparing food without a beard restraint. Interview on 04/27/10 at 2:08 PM with the Dietary Manager revealed it was the facility's policy that employees are allowed to have up to one-fourth inch (1/4") of beard before they have to cover it with a beard restraint. Review of the facility's written policy titled "Employee Sanitary Practices" revealed "All employees are to wear hairnets or restraints." Review of 483.35(l) Sanitary Conditions, F371 revealed to prevent foodborne illnesses, dietary staff must wear hair restraints, (e.g. hairnet, hat, and/or beard restraint) to prevent their hair from contacting exposed food."	F 371	The system change includes the Dietary Manager or designated cook conducting a daily inspection of the kitchen to include but not limited to dating and labeling of food items, food storage, inspection of appliances and equipment for good repair, storage of dishware and cookware after being air dried, and use of hair/beard restraints with immediate correction expected. <u>How will the facility monitor its performance to ensure that solutions are sustained?</u> The contracted RD will submit a sanitation report weekly for a period of three months or until substantial compliance is met. Findings will be submitted to the QA Team monthly for review and comment for continued compliance.	5/28/2010	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431	The facility will ensure medications are stored in a manner consistent with current accepted professional principals specifically to expirations of medications. <u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> The two meter dosed inhalers were discarded on 4/29/2010. Replacements were ordered and received on 4/29/2010 for the two non-sampled residents.		

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

PRINTED: 05/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2010
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 431	<p>Continued From page 7</p> <p>appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to store medications in a manner consistent with current accepted professional principals. Inspection of medication carts on 04/29/10 revealed the presence of two (2) metered-dose inhalers of Advair Discus which had exceeded their expiration dates, but continued to be present in the cart and available for use by residents.</p> <p>The findings include:</p> <p>During the inspection of the medication cart located on the 200 Wing on 04/29/10, two containers of Advair Discus, a combination of</p>	F 431	<p>*Please note that the it was 100 hall where the metered dose inhalers were discovered to be expired rather than the 200 wing as stated in the SOD.</p> <p><u>How will the facility identify other residents have the potential to be affected by the same deficient practice?</u></p> <p>All residents receiving metered dose inhalers as well as any other resident receiving medication from the medication carts on both 100 and 200 wing have the potential to be affected by the deficient practice.</p> <p><u>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur?</u></p> <p>Contracted Pharmacist conducted an in-service for licensed nursing staff and medication aides on 5/10/2010 regarding expiration of medication times with specific detail to meter dosed inhalers.</p> <p>A one 100% medication carts audited was conducted by the DON and KMA on 5/12/2010 and 5/19/2010 to ensure that all medication stored on the medication carts were within the date of expiration. No items found to be expired on either of the medication carts on 100 and 200 wings.</p> <p>A weekly audit will be conducted by the DON, RN Supervisor, and/or medication aide utilizing a refill report provided by the pharmacy. This report provided by the pharmacy will provide a detailed listing of medications and treatments that are due refill based upon the last fill date. This report that is being provided is a system change.</p>	
-------	--	-------	---	--

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

PRINTED: 06/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 04/29/2010
NAME OF PROVIDER OR SUPPLIER ROYAL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 8</p> <p>Salmeterol and Fluticasone utilized to control Chronic Bronchospasm and Chronic Obstructive Pulmonary Disease which had exceeded their expiration dates. Due to drug-stability issues, the Provider Pharmacy instructed nursing staff to date each container of Advair when introduced into use, to use the container for a total of thirty (30) days, then replace with a fresh container.</p> <p>Both containers of the outdated Advair had been assigned to non-sampled residents, and both residents were diagnosed with COPD (Chronic Obstructive Pulmonary Disease). For example, one container of Advair was discovered which had been dispensed by the Pharmacy on 3/25/10 and was marked by staff as being introduced into use on "3/28/10". Thus, the container should have been discarded on "4/25/10" with a new container introduced into use at that time. As a result, the container continued to be in use four (4) days after expiration. The second container of Advair had been dispensed by the Pharmacy on 3/8/10 and had been marked by staff as having been introduced into use on "3/9/10". Thus, that container should have been discarded and replaced with a new container at that time. Thus, that container continued to be present in the cart and available for use twenty-two (22) days after it expired.</p> <p>During an interview with SRNA #3/Medication Aide on 04/29/10 at 11:00 AM, the aide explained "We date the Advair when opened, then discard any remainder after 30 days". At 11:20 AM on 04/29/10, during an interview with LPN #4/Medication Nurse, she explained "Pharmacy told us we can use the Advair for 60 days, then discard". Observation of the information sheet kept in the 100 Wing Nurses' Station instructed</p>	F 431	<p><u>How will the facility monitor its performance to ensure that solutions are sustained?</u></p> <p>Findings from the weekly audit will be submitted to the QA Team monthly for a period of three months or until substantial compliance is met for review and comment for continued compliance.</p>	5/28/2010

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

PRINTED: 05/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/29/2010
NAME OF PROVIDER OR SUPPLIER ROYAL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 9 staff to use the Advair only for 30 days and then replace it with a new container.	F 431		
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. (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.	F 441	The facility will establish and maintain an Infection Control program designed to provide safe, sanitary and comfortable environment and prevent the development and transmission of disease and infection specifically ensuring that proper infection control techniques be followed while performing perineal care. <u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> Residents # 3 and # 8 were observed to make sure that no ill effects occurred from the cited alleged deficient practices. Furthermore, both of the resident bed covers were changed and housekeeping cleaned the room on 4/29/2010 after being made aware of the alleged deficiency. SRNA # 2 received one-on-one education regarding infection control practices specific to proper techniques in performing pericare. Demonstration of learning was done on 5/19/2010. SRNA # 1 was terminated prior to the completion of this POC for reasons other than related to this deficiency.	

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

PRINTED: 06/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/29/2010
--	--	--	---

NAME OF PROVIDER OR SUPPLIER ROYAL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40350
---	---

(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 441	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure proper infection control techniques during perineal care for two (2) of fifteen (15) sampled residents (Resident #3 and Resident #8).</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of Resident #3's medical record revealed diagnose which included Alzheimer Disease, Diabetes and Anemia. <p>Observation of perineal care for Resident #3 on 04/29/10 at 11:00 AM, revealed State Registered Nurses Assistant (SRNA) #2 failed to remove soiled gloves after performing perineal care and proceeded to adjust Resident #3's bed covers and clipped the resident's call bell in place.</p> <p>Interview with SRNA #2 on 04/29/10 at 11:10 AM, revealed she should have washed her hands after removing the soiled gloves and before touching anything else in room and had attended an inservice in April of this year.</p> <ol style="list-style-type: none"> Review of Resident #8's medical record revealed diagnoses which included Alzheimer Disease. <p>Observation of perineal care for Resident #8 on 04/29/10 at 1:50 PM, revealed SRNA #1 failed to remove soiled gloves after providing perineal care and before touching other items in the room.</p>	F 441	<p><u>How will the facility identify other residents have the potential to be affected by the same deficient practice?</u></p> <p>Residents who are incontinent and receive pericare from SRNA are identified to be potentially at risk to be affected by the same deficient practice.</p> <p><u>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur?</u></p> <p>All SRNA were required to watch a video specific to pericare and infection control practices as well demonstrate learning by performing pericare in front of a licensed nurse. Completion of the education was concluded on 5/25/2010.</p> <p>Additionally, random pericare audits will be conducted by the SDC, DON, or by a license nurse no less than three times weekly. This is a system change to ensure proper technique is being followed.</p> <p><u>How will the facility monitor its performance to ensure that solutions are sustained?</u></p> <p>The SDC will submit findings to the QA Team monthly for three months or substantial compliance is met for review and comment for continued compliance.</p>	5/28/2010
-------	--	-------	--	-----------

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

PRINTED: 05/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/29/2010
NAME OF PROVIDER OR SUPPLIER ROYAL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 11 Interview with SRNA #1 on 04/29/10 at 2:00 PM, revealed she was aware of proper steps in performing perineal care and had recently attended an inservice on 04/21/10.	F 441			
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to maintain clinical records in accordance with acceptable professional standards and practices for six (6) of fifteen (15) sampled residents. Residents #1, #5, #6, #7, and #13's records contained current Physician's orders with a stop date of 04/26/10, therefore the records failed to have active medication and treatment orders for 04/27/10 and 04/28/10. Further, Resident #10's record failed to	F 514	The facility will maintain clinical records in accordance with acceptable professional standards and practices specifically ensuring active medication and treatment records. <u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> Residents #1, #5, #6, # 7, & # 13 had telephone orders written on 4/26/2010 extending the orders the order for ten days. They were signed by the Physician Assistant on 4/28/10 and placed on the chart on 4/28/2010. A medication error report was written on resident # 10. The Physician Assistant was made aware of this error. No action was necessary since current orders were active beginning 3/25/2010. <u>How will the facility identify other residents have the potential to be affected by the same deficient practice?</u> All residents with physician orders ending 4/26/2010 were identified as having potential to be affected by the same deficit practice as per the audit on 4/26/2010.		

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

PRINTED: 05/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/29/2010
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 514	<p>Continued From page 12</p> <p>have Physician's orders for 03/23/10 and 03/24/10 as evidenced by the stop date of 03/22/10 and the start date for the next orders of 03/25/10.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of Resident #6's medical record revealed diagnoses which included Congestive Heart Failure, Diabetes, and Depression. <p>Review of the Physician's orders dated 02/24/10 through 04/26/10 revealed orders for fifteen (15) medications and two (2) treatments. The facility's Medication Administration Records (MARs), and Treatment Administration Records (TARs) revealed the facility administered the medications and treatments on 04/27/10 and 04/28/10, however the facility was unable to provide evidence of current physician orders to administer the medications and treatments.</p> <ol style="list-style-type: none"> Review of Resident #7's medical record revealed diagnoses which included Dementia, Hypertension, and Depression. <p>Review of the Physician orders dated 02/24/10 through 04/26/10 revealed orders for fourteen (14) medications. The facility's Medication Administration Records (MARs) revealed the facility administered the medications on 04/27/10 and 04/28/10, however the facility was unable to provide evidence of current physician order to administer the medications.</p> <ol style="list-style-type: none"> Review of Resident #13' medical record revealed diagnoses which included Mental Retardation, Epilepsy, and Congestive Heart Failure. 	F 514	<p>All residents with the physician orders ending 3/23/2010 were identified as having potential to be affected by the same deficient practice.</p> <p><u>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur?</u></p> <p>An in-service was held with the medical records coordinator on 5/14/2010 by the DON. This in-service included mapping out a schedule of when to run the orders so that they may be checked timely and signed by the physician. The system change is where a copy of the newly checked orders will be placed on the chart awaiting physician signature.</p> <p><u>How will the facility monitor its performance to ensure that solutions are sustained?</u></p> <p>The Assistant Administrator will conduct a weekly audit of 25% of resident clinical records to ensure that physician orders are active and timely. Findings from the audit will be submitted to the QA Team for review and comment for continued compliance.</p> <p>This Plan of Correction constitutes allegation of compliance.</p>	5/28/2010
-------	--	-------	--	-----------

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

PRINTED: 05/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/29/2010
NAME OF PROVIDER OR SUPPLIER ROYAL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 514	<p>Continued From page 13</p> <p>Review of the "Physician's Orders" dated 02/24/2010-04/26/2010, revealed orders for ten (10) scheduled medications, and two (2) different skin treatments. The facility's Medication Administration Records (MARs), and Treatment Administration Records (TARs) revealed the facility administered the medications and treatments on 04/27/10 and 04/28/10, however the facility was unable to provide evidence of having a current physician orders to administer the medications and treatments.</p> <p>4. Review of Resident #1's medical record revealed diagnoses which included Hypertension, Dementia, and Congestive Heart Failure.</p> <p>Review of the Physician orders dated 02/24/10 through 04/26/10 revealed orders for twenty-one (21) medications and five (5) treatments. The facility's Medication Administration Records (MARs), and Treatment Administration Records (TARs) revealed the facility administered the medications and treatments on 04/27/10 and 04/28/10, however the facility was unable to provide evidence of current physician orders to administer the medications and treatments.</p> <p>5. Review of Resident #5's medical record revealed diagnoses which included Hypertension, Anemia, and Gout.</p> <p>Review of the Physician's orders dated 02/24/10 through 04/26/10 revealed orders for seventeen (17) medications and two (2) treatments. The facility's Medication Administration Records (MARs), and Treatment Administration Records (TARs) revealed the facility administered the medications and treatments on 04/27/10 and 04/28/10, however the facility was unable to</p>	F 514			

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

PRINTED: 06/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/29/2010
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 514	<p>Continued From page 14</p> <p>provide evidence of current physician orders to administer the medications and treatments.</p> <p>6. Review of Resident #10's medical record revealed diagnoses which included Clostridium Difficile Colitis, Chronic Obstructive Pulmonary Disease, Hypertension, and Diabetes Mellitus. Review of the medical record revealed Resident #10 had physician's orders dated 01/22/2010 and expired on 03/22/2010; however record review revealed the new physician's orders did not begin until 03/26/2010. Review of the Medication Administration Record (MAR) revealed Resident #10 had received the twenty (20) scheduled medications during this two day time period (03/23/2010 to 03/24/2010) without active physician's orders.</p> <p>Interview with the Charge Nurse on Resident #10's unit, Licensed Practical Nurse (LPN) #2, on 04/29/10 at 2:40 PM, revealed the medication was given without an active physician's order and had not been noticed. LPN #2 stated, normally there would be continue medication order written by the Medical Doctor (MD) or Physician Assistant (PA). Interview with Registered Nurse (RN) #2, on 04/29/10 at 2:50 PM, revealed she thought the PA had written a continue medication order, however, the facility was unable to provide evidence of a continue medication order written for the time period of 03/23/2010 to 03/24/2010. Interview with the Director of Nursing (DON) on 04/28/10 at 10:30 AM revealed the previous DON had the computer system set up to stagger the orders from mid month to mid month. He further stated he realized several residents failed to have current orders for 04/27/10 and 04/28/10. Interview with the Physician Assistant (PA) on 04/28/10 at 11:15 AM revealed she was not aware some residents did not have current</p>	F 514		
-------	---	-------	--	--

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

PRINTED: 05/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/29/2010
NAME OF PROVIDER OR SUPPLIER ROYAL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	Continued From page 15 physician's orders as the stop dates were 04/26/10 and she felt like it was a computer system problem.	F 514			

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

PRINTED: 05/11/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2010
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	INITIAL COMMENTS	K 000	Preparation and/or execution of this Plan of correction does not constitute admission or agreement to the alleged cited deficiencies.	
K 039 SS=F	<p>A Life Safety Code survey was initiated and completed on 04/27/10. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "F", wide spread, with the potential to effect all residents in the building.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access according to NFPA standards.</p> <p>The findings include:</p> <p>Observations on 04/27/10 at 1:10 PM revealed that linen carts were being stored in the A corridor/hallway. Observations on 04/27/10 at 2:00 PM during the survey revealed linen carts were being stored in the B corridor/hallway.</p> <p>During interview with the Maintenance Director on 04/27/10 at 2:05 PM he stated the linen carts were stored there because the facility did not have any other place to put them.</p> <p>Actual NFPA Standard: 19.2.3.3* Any required aisle, corridor, or ramp shall be not less than 4 ft (1.2 m) in clear width where serving as means of egress from patient sleeping rooms.</p>	K 039	<p>Royal Manor, Inc. submits this Plan of Correction as evidence of adherence to state and federal requirements for licensure and participation in the Medicare and Medicaid programs.</p> <p>This document not intended to waive any defense, legal or equitable, in administrative, civil, or criminal proceedings.</p> <p>RECEIVED MAY 21 2010 BY: _____</p> <p>The facility will maintain width of aisles or corridors (clear and unobstructed) at least 4 feet or according to NFPA standards.</p> <p><u>What corrective action will be accomplished for those residents found to have been effected by the deficient practice?</u></p> <p>No resident was identified.</p> <p>The linen carts were removed from the halls and will stored in the central bath rooms on both 100 and 200 wings.</p> <p><u>How will the facility identify other residents have the potential to be affected by the same deficient practice?</u></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Benjamin J. Sparks</i>	TITLE Administrator	(X6) DATE 5-21-10
--	------------------------	----------------------

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

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

PRINTED: 05/11/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2010
NAME OF PROVIDER OR SUPPLIER ROYAL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 039	Continued From page 1 The aisle, corridor, or ramp shall be arranged to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers. Exception No. 1: Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (112 cm) in clear and unobstructed width. Exception No. 2: Exit access within a room or suite of rooms complying with the requirements of 19.2.5.	K 039	Residents who use hallways on 100 and 200 wings have the potential to be affected by the same deficient practice. <u>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur?</u> Nursing staff was in-serviced on 5/20/2010 by DON regarding the importance of keeping the hallways clear and unobstructed specifically that items though on wheels must not be in one place for a period of thirty minutes or greater. Additionally, the large linen carts will be stored in the central bath on each wing. Smaller linen carts will be purchased for use on halls, but will also be stored in the central baths when not be used on the halls. Signs will be posted throughout each hallway "temporary parking" prompt staff to move the item frequently or store the item when not in use. This is a system change. <u>How will the facility monitor its performance to ensure that solutions are sustained?</u> The license nurse will monitor the hallways at least once per shift to ensure that hallways are clear and unobstructed for a period of no less than three months or until substantial compliance is met. Findings will be submitted to the Quality Assurance Team for review and comment for continued compliance.	
K 147 SS=E	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, it was determined the facility failed to maintain electrical wiring and equipment according to NFPA standards. The findings include: Observations on 04/27/10 at 1:47 PM revealed power strips which had medical equipment plugged into them, in rooms 209, 216, and 221. During interview with Maintenance Director on 04/27/10 at 1:50 PM he stated the facility's policy was to not plug medical equipment into power strips but sometimes nurses would mistakenly plug medical equipment into power strips.			5/28/2010

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

PRINTED: 05/11/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2010
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 147	<p>Continued From page 2</p> <p>Actual NFPA Standard: NFPA 99 3-3.2.1.2 All Patient Care Areas. (See Chapter 2 for definition of Patient Care Area.)</p> <p>(a) * Wiring, Regular Voltage.</p> <p>1. * Circuits. Branch circuits serving a given patient bed location shall be fed from not more than one normal branch circuit distribution panel. When required, branch circuits serving a given patient bed location shall be permitted to be fed from more than one emergency branch circuit distribution panel. Critical care areas shall be served by circuits from (1) critical branch panel(s) served from a single automatic transfer switch and (2) a minimum of one circuit served by the normal power distribution system or by a system originating from a second critical branch transfer switch. Exception: Branch circuits serving only special-purpose outlets or receptacles (e.g., portable X-ray receptacles) need not conform to the requirements of this section.</p> <p>2. Grounding.</p> <p>a. Grounding Circuitry Integrity. Grounding circuits and conductors in patient care areas shall be installed in such a way that the continuity of other parts of those circuits cannot be interrupted nor the resistance raised above an acceptable level by the installation, removal, or replacement of any installed equipment, including power receptacles.</p> <p>b. * Reliability of Grounding. In all patient care areas the reliability of an installed grounding circuit to a power receptacle shall be at least equivalent to that</p>	K 147	<p>The facility will maintain electrical and wiring equipment according to NFPA standards specifically ensuring that power strips are not used to provide power for medical equipment.</p> <p><u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>No resident was specifically identified.</p> <p>Rooms 209, 216, & 221 were inspected on 4/27/2010 by the maintenance director and DON to make sure that all medical equipment was plugged into the proper power source.</p> <p><u>How will the facility identify other residents have the potential to be affected by the same deficient practice?</u></p> <p>Residents requiring a power source for medical equipment were identified to be at risk for having the potential to be at risk for the alleged deficient practice. A one time 100 % room by room audit was completed on 5/19/2010 to ensure that all medical equipment was plugged into proper power sources</p> <p><u>What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur?</u></p> <p>All staff was in-serviced by the maintenance director on 5/19/2010 regarding the safe and proper power sources for the medical equipment.</p>	

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

PRINTED: 06/11/2010
FORM APPROVED
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2010
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 147	<p>Continued From page 3</p> <p>Copyright NFPA provided by an electrically continuous copper conductor of appropriate ampacity run from the receptacle to a grounding bus in the distribution panel. The grounding conductor shall conform to NFPA 70, National Electrical Code. Where metal receptacle boxes are used, the performance of the connection between the receptacle grounding terminal and the metal box shall be equivalent to the performance provided by copper wire no smaller than No. 12 AWG.</p> <p>Exception: Existing construction that does not use a separate grounding conductor shall be permitted to continue in use provided that it meets the performance requirements in 3-3.3.2, Grounding System in Patient Care Areas.</p> <p>3. * Grounding Interconnects. In patient care areas supplied by the normal distribution system and any branch of the essential electrical system, the grounding system of the normal distribution system and that of the essential electrical system shall be interconnected.</p> <p>4. Circuit Protection.</p> <p>a. * The main and downstream ground-fault protective devices (where required) shall be coordinated as required in 3-3.2.1.6.</p> <p>b. * If used, ground-fault circuit interrupters (GFCIs) shall be approved for the purpose.</p> <p>5. Wiring in Anesthetizing Locations.</p> <p>a. Wiring. Installed wiring shall be in metal raceway or shall be as required in NFPA 70, National Electrical Code, Sections 517-60 through 517-63.</p> <p>b. Raceway. Such distribution systems shall be</p>	K 147	<p>Additionally, the maintenance director designated proper power sourced on each of the room by a red receptacle cover and the wording "Medical Equipment only." This is a system change.</p> <p><u>How will the facility monitor its performance to ensure that solutions are sustained?</u></p> <p>The maintenance director will conduct room by room audits no less than three times weekly for a period of three months or until substantial compliance is met. Findings will be submitted to the QA Team monthly for review and comment to ensure continued compliance.</p> <p>This Plan of Correction constitutes allegation of compliance.</p>	5/28/2010
-------	--	-------	---	-----------

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

PRINTED: 05/11/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2010
NAME OF PROVIDER OR SUPPLIER ROYAL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 4 run in metal raceways along with a green grounding wire sized no smaller than the energized conductors. c. Grounding to Raceways. Each device connected to the distribution system shall be effectively grounded to the metal raceway at the device. d. Installation. Methods of installation shall conform to Articles 250 and 517 of NFPA 70, National Electrical Code. e. Battery-Powered Emergency Lighting Units. One or more battery-powered emergency lighting units shall be provided in accordance with NFPA 70, National Electrical Code, Section 700-12(e). (b) Wiring, Low-Voltage. 1. Fixed systems of 30 V (dc or ac rms) or less shall be ungrounded, and the insulation between each ungrounded conductor and the primary circuit, which is supplied from a conventionally grounded distribution system, shall provide the same protection as required for the primary voltage. Exception: A grounded low-voltage system shall be permitted provided that load currents are not carried in the grounding conductors. 2. Wiring for low-voltage control systems and nonemergency communications and signaling systems shall not be required to be installed in metal raceways in anesthetizing locations. (c) Switches, Anesthetizing Locations. Switches controlling ungrounded circuits within or partially within an inhalation anesthetizing location shall have a disconnecting pole for each conductor. (d) Receptacles. 1. * Types of Receptacles. Each power receptacle	K 147		

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

PRINTED: 05/11/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2010
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 147	<p>Continued From page 5</p> <p>shall provide at least one separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug despite electrical and mechanical abuse. Special receptacles (such as four-pole units providing an extra pole for redundant grounding or ground continuity monitoring; or locking-type receptacles; or, where required for reduction of electrical noise on the grounding circuit, receptacles in which the grounding terminals are purposely insulated from the receptacle yoke) shall be permitted.</p> <p>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.</p>	K 147		

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

JUN 04 2010

PRINTED: 06/24/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2010
NAME OF PROVIDER OR SUPPLIER ROYAL MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000	Preparation and/or execution of this Plan of correction does not constitute admission or agreement to the alleged cited deficiencies.	
K 068 SS=D	<p>This Comparative Federal Life Safety Code (LSC) Survey was conducted on May 18, 2010. It was conducted as per the requirements of the Federal Register at 42CFR 483.70 (a) using the existing Health Care Section of the 2000 edition of the LSC and its referenced publications. This building was partially sprinklered and housed 83 beds. On the day of survey, census was 78.</p> <p>The deficiencies determined during the survey are as follows: NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based upon observation and staff interview it was determined during the survey that the facility failed to provide a complete sprinkler system. The findings included:</p> <p>Approximately 10:30 AM, it was observed that overhang (approximately 20'x16') with</p>	K 058	<p>Royal Manor, Inc. submits this Plan of Correction as evidence of adherence to state and federal requirements for licensure and participation in the Medicare and Medicaid programs.</p> <p>This document not intended to waive any defense, legal or equitable, in administrative, civil, or criminal proceedings.</p> <p>The facility will provide complete sprinkler coverage for all portions of the building.</p> <p><u>What corrective actions will be accomplished for those residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</u></p> <p>The overhang structure was removed on 6/2/2010.</p> <p><u>How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken?</u></p> <p>Prior to the removal of the structure on 6/2/2010, residents residing in the facility had the potential to be affected by the cited deficiency.</p> <p><u>What measures or systemic changes will ensure that the deficient practice will not recur?</u></p> <p>The structure was removed on 6/2/2010. Employees were in-serviced by the maintenance director on 6/9/2010 regarding sprinkler needs of a facility.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Benjamin J. Sparks TITLE Administrator DATE 6-3-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 05/24/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2010
NAME OF PROVIDER OR SUPPLIER ROYAL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40368	
(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 058	Continued From page 1 combustible construction located at the designated smoking area did not have sprinkler coverage. This was verified with maintenance staff at the time of discovery.	K 058	<u>How will the corrective action(s) be monitored to ensure that the deficient practice will not recur?</u> Administrator will oversee any and all construction to ensure that proper sprinkler function be included as needed. Such construction will be submitted to the Quality Assurance Team for approval prior to any construction.	6/11/2010
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based upon observation and staff interview during the survey, it was determined that the facility failed to provide the sprinkler system continuously maintained in reliable operating condition. The findings included: Approximately at 10:30 AM, it was observed that main valve of the sprinkler system located in the riser room did not have a tamper switch that would sound when the valve was closed. This was verified with maintenance staff at the time of discovery.	K 061	<u>What corrective actions will be accomplished for those residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</u> A tamper switch is scheduled to be installed June 9, 2010 by Korsen, a contracted sprinkler company. No specific resident identified. <u>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</u> Residents residing in the facility prior to the addition of the tamper switch have potential to be affected by the cited deficiency. <u>What measures or systemic changes will ensure that the deficient practice will not recur?</u> Korsen is scheduled to install the tamper switch on June 9, 2010 at which time will become "live" with continuous monitoring through AOT monitoring systems. The maintenance director will check the operation of the tamper switch at least monthly. Korsen will check the operation of the tamper switch at least quarterly.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: E07W21

Facility ID: 100442

If continuation sheet Page 2 of 2

K QSI (cont)

How will the corrective action(s) be monitored to ensure that the deficient practice will not recur?

Findings will be submitted to the Quality Assurance Team for review and comment for three months or until substantial compliance met.

5/11/2010

This Plan of Corrections constitutes allegation of compliance.