

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

PRINTED: 07/14/2014
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 06/27/2014
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NAME OF PROVIDER OR SUPPLIER ROYAL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40358
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(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
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F 000 INITIAL COMMENTS

F 000

An Abbreviated Survey investigating KY00021831 was initiated on 06/26/14 and concluded on 06/27/14. KY00021831 was unsubstantiated with an unrelated deficiency cited at a Scope and Severity of an "E".

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

F 323

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as was possible. Observation during initial tour of the facility, and throughout the survey revealed toiletries, Germ X hand sanitizer and Sanicloth Bleach Wipes were unattended and accessible to wandering residents.

The findings include:

Interview with the Administrator on 06/27/14 at 4:00 PM, revealed there was no facility policy related to the storage of toiletries.

Observation on 06/26/14 at 5:30 PM during the initial tour of the facility, of the general bathroom on the A Unit, revealed the bathroom door was

To the best of my knowledge and belief, as an agent of Diversicare of Nicholasville, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.

Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Theresa Wallis* TITLE: *Administrator* (X6) DATE: *7/17/14*

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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NAME OF PROVIDER OR SUPPLIER ROYAL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356
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F 323 Continued From page 1
 unlocked. Observation revealed there was a tube of Secura Protective Ointment (skin protectant) on the back of the toilet, and two (2) bottles of "Apricot Shampoo and Body Wash" with a label which stated, 'caution-external use only' on the shower hand rail. Continued observation during the initial tour revealed an unlocked cabinet on the wall in the general bathroom on A Unit which contained: a bottle of Moisture Skin Care Lotion with a label which stated "external use only"; two (2) cans of McKesson Shave Cream with a label which stated "keep out of reach of children"; a bottle of Body Lotion which stated "keep out of reach of children"; a tube of Aloe Vesta Protective Ointment (skin protectant); and a box of individually wrapped Sanicloth Bleach Wipes with a label which stated "keep out of reach of children".

Observation on 06/26/14 at 5:50 PM on the A Unit, revealed an unattended medication cart with a bottle of "Germ-X" hand sanitizer on top of the cart. The label on the "Germ X" hand sanitizer stated, "if swallowed call poison control right away".

Interview on 06/26/14 at 6:10 PM with the Charge Nurse for the A Unit, revealed there were no wandering residents on the A Unit; however, occasionally the B Unit side wandering residents came to the A Unit. She stated the toiletries, as well as, the "Germ X" and Sanicloth Bleach Wipes should not have been left out accessible to any residents.

Observation on 06/26/14 at 7:07 PM, of the general bathroom for the B Unit revealed the bathroom door to be unlocked. Continued observation revealed a gallon jug of "Apricot

F 323 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been negatively impacted by the deficient practice, however; when Issue was identified on 6/26/14, all unattended hazardous items located in the A Unit and B Unit general bathroom/shower room were secured in locked cabinet by the Director of Nursing Services. Sanitizer was removed from top of medication cart and secured in locked drawer on this date by the Director of Nursing Services. On 6/27/14, identified potentially hazardous items were removed from sink counters in Rooms 108, 107, 221 and 215 by the Director of Nursing Services. In addition, an all-house sweep of 100% resident rooms was inspected for similar findings, with any potentially hazardous toiletries being immediately secured. The items were secured either by placing in plastic bin and stored in top of closet for bed-ridden or immobile residents, and placed in zip lock plastic gallon bags, labeled for resident, and placed in bed side drawer for mobile residents. This was completed by all nursing staff currently on-shift under the direction of the Director of Nursing Services.

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NAME OF PROVIDER OR SUPPLIER ROYAL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40358	
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F 323	Continued From page 2 Shower and Body Wash" with no lid on it, and a label which stated for "external use only", sitting on a shower chair. Observation on 06/27/14 at 11:00 AM, revealed a bottle of "Xplosion Mouth Wash" with a label which stated, "if ingested call poison control immediately" in room 108 on the counter at the sink. Observation on 06/27/14 at 11:20 AM, revealed a bottle of "Apricot Shampoo and Body Wash" with a label which stated "external use only", and a bottle of Aloe Vesta Cleansing Foam with a label which stated "external use only" in room 107 on the counter at the sink. Interview with State Registered Nursing Assistant (SRNA) on 06/27/14 at 1:40 PM, revealed there were two (2) wanderers in the building, and one (1) of the two (2) wandered into other residents' rooms. Observation on 06/27/14 at 4:15 PM, revealed: a bottle of Baby Oil with a label which stated "avoid drinking, avoid inhaling", and "if inhaled and a breathing problem occurs call physician"; four (4) bottles of Aloe Vesta 3 ointment (skin protectant); and a can of McKesson Shave Cream with a label which stated "keep out of reach of children" on the counter at the sink in room 221. Observation on 06/27/14 at 4:20 PM, revealed a bottle of McKesson Deodorant Spray with a label which stated "if inhaled, get medical attention and call poison control" on the counter at the sink in room 215. Interview, on 06/27/14 at 2:09 PM, with the	F 323	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. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? All nursing staff has been in-serviced in regards to appropriate storage of resident toiletry items, both in resident rooms and shower rooms, by the Director of Nursing Services and Nursing Supervisors. This education began on 6/27/14 with all staff currently on-shift by the Director of Nursing Services, and continued with all additional on-coming nursing staff by the Director of Nursing Services and/or Nursing Supervisors, achieving 100% nursing staff by 7/2/14.	

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NAME OF PROVIDER OR SUPPLIER ROYAL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40358		
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F 323	Continued From page 3 Director of Nursing (DON) revealed residents had been allowed to keep their toiletries out on the sink counters; however, she could see how this could be a risk for wandering residents. She indicated Sanicloth Bleach Wipes and toiletries should not be left out in the general bathrooms and "Germ X" should not be left unattended as they could be potentially dangerous for residents. She stated there were two (2) wandering residents in the facility and one (1) of the two (2) residents did wander into other residents' rooms. Interview, on 06/27/14 at 2:25 PM, with the Administrator revealed he was new to the facility and was unaware residents' toiletries and other hazardous items, such as "Germ X", was being left out accessible to residents. He stated the toiletries should be labeled with residents' names, bagged and put in their dresser drawer. The Administrator stated staff should take the bag of toiletries to and from the shower room and not leave the toiletries in the general bathrooms. Further interview revealed the facility would be completing an inservice with all staff related to these items being left out and accessible to residents and how to ensure the items were stored correctly.	F 323	How will the facility monitor performance to ensure solutions are sustained? In addition to the education provided and detailed in (3), the Charge Nurses have been educated by the Director of Nursing that they are responsible for review of shower rooms/general bathrooms on each of their assigned shifts. This education was completed on 7/2/14 for all licensed staff. In addition, weekly audits of all resident rooms and shower rooms/general bathrooms for potential hazardous items shall be completed by the Director of Nursing Services and/or assigned Nurse Manager or Charge Nurse on a weekly basis times 12 weeks, with any identified issue being addressed immediately. Results of these audits will be reviewed at the monthly Quality Assurance Meeting times 3 months to determine if additional actions are warranted.		

7-3-14