

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

PRINTED: 09/22/2010
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 09/09/2010
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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 000	INITIAL COMMENTS	F 000	Preparation and/or execution of this Plan of correction does not constitute admission or agreement to the alleged cited deficiencies.	
F 282 SS=D	<p>An Abbreviated Survey to investigate allegations in AROs KY00014887, KY00015020, and KY00015021 was conducted 09/08-09/10. ARO 15021 was substantiated with no deficiencies cited. ARO KY00014887 and ARO KY00015020 were substantiated with deficiencies cited, with the highest scope and severity being a "D".</p> <p>483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility to ensure implement the Comprehensive Plan of Care for one (1) of three (3) sampled residents (Resident #1), related to transfers.</p> <p>The findings include:</p> <p>Review of Resident #1's clinical record revealed the resident was admitted with diagnosis which included Dementia. Review of an X-ray report, dated 07/17/10, revealed Resident #1 was identified to have generalized Osteoporosis of the shoulders.</p> <p>Review of the Comprehensive Care Plan, dated 01/26/10 revealed Resident #1 was to be transfer by two (2) staff when using a Hoyer lift. Additional review of the clinical record for Resident #1 revealed a Social Services Note, dated 07/28/10 which detailed a complaint that the resident was</p>	F 282	<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 ensure that that the comprehensive care plan is implemented.</p> <p><i>What corrective action will be accomplished for those residents found to be affected by the deficient practice?</i></p> <p>Resident #1 was assessed on 7/28/2010 by LPN Lowe after being made aware of the allegation. The clinical record reflects in its documentation that there were not any obvious signs and symptoms of injury. Additionally, Dr. John Richard, attending physician and Medical Director, assessed the resident on 7/28/2010 with no mention of injury.</p> <p>The two employee involved in the incident were immediately suspended beginning 7/28/2010 for pending outcome of facility investigation. Both employees were suspended for two days. Additionally, both employees received education and training regarding following plan of care on 7/28/2010.</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10-20-10
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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.

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F 282	Continued From page 1 transferred by two staff members without use of a Hoyer lift. Additional record review found no documented evidence the resident received an injury or that nursing staff were made aware of the allegation. Interview, on 09/10/10 at 2:50 PM, with State Registered Nurse Aide (SRNA) #8 revealed she and another SRNA had transferred Resident #1 on 07/27/10 without using the Hoyer lift. She explained it had been a "crazy" day and were late getting the resident up. The SRNA stated she was aware a Hoyer lift was to be used for Resident #1. Interview, on 09/10/10 at 2:55 PM, with the Director of Nursing (DON) revealed he became aware staff had not used the Hoyer lift on Resident #1 on 07/28/10. He stated he conducted an investigation and determined staff had not used the lift for transfer on 07/27/10. In addition the DON stated the resident was assessed and determined to have injuries as a result of the 07/27/10 transfer. Review of the facility's "Transfer Safety Policy and Procedure" revealed licensed staff would assess residents and relay the assessment information to the Minimum Data Set (MDS) office. The MDS office would utilize the assessment information to determine the needs for a Hoyer lift and other assistive devices.	F 282	<i>How will the facility identify other residents having the potential to be affected by the same deficient practice?</i> All residents were reviewed and assessed 8/3-6/2010 by a licensed nurse to determine that the resident care sheets were correct and that the care interventions listed on the care sheets were being implemented and carried out accordingly. Corrections and clarifications regarding care were adjusted as indicated at that time. <i>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?</i> The staff received education on 7/28/2010 from the Staff Development Coordinator and Director of Nursing regarding the importance of following the plan of care and understanding of the transfer guide with weight bearing status in conjunction with using prudent nursing judgment. Additional training regarding shift resident assignment relating to clarifications of care interventions and agreement to provide care as per the resident care sheets/plan of care was completed on 10/20/2010.	10/21/2010	
F 514 SS=D	483.75(j)(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;	F 514			

F2B2 (continued)

The facility began utilizing a new tool, Resident Transfer Assessment on 8/3/2010. This tool will be utilized upon admission, quarterly, and with annual or significant changes. This tool establishes a transfer guide based upon the weight bearing status while allowing nursing staff to make nursing measure judgment. Data obtained from the assessments as well as other as all other assessments will be reflected in the resident care plan and the resident care sheets (an extension of the care plan). The system change will be reflected in how resident assignments are deployed by the shift supervisor to the nursing assistants. During report the supervisor will ask the nursing assistants to review the assignment which includes the resident care sheets to ensure the nursing assistant understands the care interventions and delivery of service.

Clarifications will be as indicated at the time the nurse assistant accepts the resident care assignment. By accepting the assignment, the nursing assistant is agreeing to provide care to resident as per the resident care sheet. The resident care sheets will be turned back in to the supervisor at the end of the shift with signature of the care provider for validation of care provided per plan of care.

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

The shift supervisor will observe and monitor delivery of care service throughout the shift. Validation of the delivery of care per the resident care sheet / plan of care will be done on 7 residents (approximately 10% of nursing facility licensed census) daily for a period of three months or until substantial compliance is met. Assessments, Care Plans, and resident care sheets will be updated as indicated. One-to-one education, coaching, and disciplinary actions will be as indicated. Findings will be presented to the Quality Assurance Team for review and comment.

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F 514	<p>Continued From page 2</p> <p>accurately documented; readily accessible; and systematically organized.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure staff accurate document bowel movements (BMs) in the clinical records for one (1) of three (3) sampled residents (Resident #3).</p> <p>The findings include:</p> <p>Review of the clinical record for Resident #3 revealed the resident was admitted to the facility with diagnosis which included Dementia and Lumbago. Review of the Physician's orders revealed the resident was to receive as needed (PRN) medication for lack of bowel movements (BMs). These medications were: Sorbitol 70% solution (a laxative) every second day no BM, Fleets enema every third day with no BM, and Glycerin suppository for no BM in three days. Review of Resident #3's Daily Care Log revealed no documented evidence the resident had a bowel movements for six (6) days, from May 26 through May 31, 2010. Review of the Medication Administration Record (MAR) revealed no evidence Resident #3 received the bowel medications as ordered. The Sorbitol was given on the fifth day with no BM and the Glycerin</p>	F 514	<p>The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; systematically organized. Specifically, the facility will ensure that bowel movements are accurately documented in the clinical record.</p> <p><i>What corrective action will be accomplished for those residents found to be affected by the deficient practice?</i></p> <p>Resident # 3 was assessed by Dr. Nikki Pittman on 6/2/2010. Her assessment determined to her to be "stable" condition. In conjunction with the findings of the physician and with clinical presentation, resident # 3 did not exhibit a clinical negative outcome from the cited deficient practice.</p> <p>Resident # 3 clinical record was reviewed by the Director of Nursing to ensure the records were complete, accurate, assessable, and organized. Areas identified as opportunities for improvement were made part of education and training for staff on 9/23/2010 as well a quality assurance focus for monitors.</p>	
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F 514	<p>Continued From page 3</p> <p>suppository was given on the sixth day without a BM.</p> <p>Interviews, during the survey, with State Registered Nurse Aides (SRNAs) #3 and #4, Certified Medication Aides (CMAs) #5 and #8, Licensed Practical Nurses (LPNs) #1, #2 and #3, and Registered Nurse (RN) #2 revealed the SRNAs documented BMs on the resident "Daily Care Log" and then the person assigned to give medications during the 3:00 PM to 11:00 PM shift would review the log and compile a list of residents who required medications, related to the lack of having a BM.</p> <p>Interview, on 09/10/10 at 3:13 PM, with the Director of Nursing (DON) revealed he conducted a random review of the laxative list weekly to ensure staff were implementing the facility's bowel protocol. He stated he was familiar with Resident #3 and did not believe the resident would go for six (6) days without a BM. The DON stated the resident would usually have a daily BM. In additional interview, at 3:41 PM, the DON stated he could no locate the laxative list for the dates May 26th through May31, 2010, but had found the SRNA assignment sheets which indicated Resident #3 had bowel movements during the stated time frame. The DON stated the problem was not a failure to follow the bowel protocol but a failure of staff to accurately document bowel movements.</p> <p>Review of the SRNA assignment sheets revealed Resident #3 had a bowel movement on 05/26/10, 05/27/10 and 05/29/10.</p>	F 514	<p><i>How will the facility identify other residents having the potential to be affected by the same deficient practice?</i></p> <p>It can be determined that all resident within the facility are at risk for the same deficient practice as all the residents have bowel movements that should be accurately recorded. For that reason, a one time, comprehensive review of residents clinical record was completed by the medical records coordinator and director of nursing was completed on 10/20/2010. Areas of opportunity were compiled and set to become as part of the medical record quality assurance focus monitors and education and training.</p> <p><i>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur?</i></p> <p>Based on the findings from the abbreviated survey and clinical record review, the compiled list of opportunity areas for improvement were added specifically to the scheduled medical record quarterly review and thinning process. Additionally, education and training would coincide with identified areas. This serves as component of the system change. (continued)</p>	10/21/2010

F514 (continued)

Nursing staff received education and training on 9/23/2010 by the Staff Development Coordinator regarding the importance accurately recording clinical data in the in the appropriate and designated recording place. The training also included the role of the nurse aide, the medication aide, licensed personal and the interdisciplinary team in ensuring accurate monitoring of documentation as well as complications and signs and symptoms to report. The 7-3 nurse will establish the daily laxative list. The laxative list being developed by the licensed nurse is another part of the system change. Additionally, it will be the responsibility of day shift supervisor to follow up on the previous nights interventions and documentation.

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

The facility will utilize the compiled list of clinical record areas for opportunity for improvement for monthly and/or quarterly focus for monitors. For example, the Director of Nursing or designee will reconcile resident care flow records, laxative lists, and medication administration records to ensure the resident are having bowel movements at least every three days, proper utilization of bowel protocol regime, and accurate documentation on MARS reflecting intervention. This reconciliation will take be conducted at least three times weekly for three months or until substantial compliance is achieved. One-on-One education, coaching, and disciplinary action will be as indicated. Findings will be submitted to the Quality Assurance Team for review and comment monthly.

This Plan of Correction constitutes allegation of compliance.