

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

PRINTED: 05/30/2014  
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  05/22/2014
NAME OF PROVIDER OR SUPPLIER  ROYAL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SPARKS AVENUE NICHOLASVILLE, KY 40356		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  A Standard Survey was initiated on 05/20/14 and concluded 05/22/14 with no deficiencies cited.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Signature]* Benjamin J. Spitzer Administration 5-30-14

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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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  05/20/2014
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  CFR: 42 CFR 483.70(a)  BUILDING: 01  PLAN APPROVAL: 06/10/75  SURVEY UNDER: NFPA 101 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One (1) story Type III (200)  SMOKE COMPARTMENTS: Four (4) smoke compartments  FIRE ALARM: Complete fire alarm system  SPRINKLER SYSTEM: Complete (wet) sprinkler system  GENERATOR: One (1) Type II Diesel generator.  A standard Life Safety Code Short Form Survey was conducted on 05/20/14. The facility was found to be in compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) the facility is licensed for seventy-three (73) beds with a census of sixty (60) on the day of the survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Signature]* 5-30-14  
Benjamin J. Sparks Administrator 5-30-14

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