

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

PRINTED: 08/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/28/2015
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NAME OF PROVIDER OR SUPPLIER DOVER MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 112 DOVER DRIVE GEORGETOWN, KY 40324
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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)	(X5) COMPLETION DATE
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{F 000} INITIAL COMMENTS

An offsite survey was conducted and based on the acceptable Plan of Correction (POC) the facility was deemed to be in compliance as alleged on 08/20/15.

{F 000}

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER-SUPPLIER/CLIA IDENTIFICATION NUMBER: 105295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/07/2015
NAME OF PROVIDER OR SUPPLIER DOVER MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 112 DOVER DRIVE GEORGETOWN, KY 40324	
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F 000 INITIAL COMMENTS

F 000

An Abbreviated Survey investigating KY#00023410 was initiated on 07/06/15 and concluded on 07/07/15. KY#00023410 was substantiated and deficiencies were cited at the highest Scope and Severity (S/S) of a "D".

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

F 282

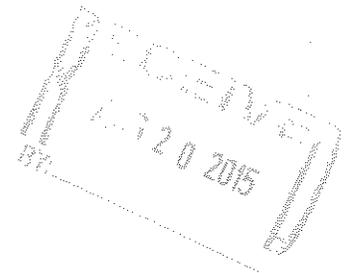
The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:

Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Care Plan was implemented for one (1) of four (4) sampled residents, (Resident #1). Resident #1 was care planned to be assist of two (2) for all transfers; however, two (2) Certified Nursing Assistants, (CNA) on consecutive days of 06/18/15 and 06/19/15, within twenty hours (20), preformed transfers of Resident #1 with assist of one (1) which resulted in Resident #1 receiving skin tears.

The findings include:

Review of the facility's policy titled "Safety, General Guidelines for Resident Safety" not dated, revealed support should be provided to the resident's body during positioning, transfers, and ambulation. Avoid pulling on resident's extremities. Staff should use protective



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michael J. Tucker</i>	TITLE Administrator	(X6) DATE 8/20/15
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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ISSUANCE DATE 07/17/2015
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equipment to prevent damage to the resident's skin. The Lift Free program involves evaluation of the resident's physical needs and abilities. Residents are evaluated for the type of lift in order to provide the safest lifting technique. The Care Plan incorporates the results of this evaluation process.

Review of the facility's policy titled "Abuse Prevention Policy and Procedure" not dated, revealed at the beginning of each shift. CNA must read and follow the care plan exactly for each assigned resident. Any questions concerning care should be directed to the nurse or MDS. The CNA is responsible for following the care plan and cannot change or ignore a resident's care plan. Resident's care plans that document two (2) assist must have assist of two (2).

Record review revealed the facility admitted Resident #1 on 02/03/09 with diagnosis of Muscle Weakness, Anxiety, Macular Degeneration, Depression and Parkinson's disease. Review of the Annual Minimum Data Set (MDS) Assessment dated 04/27/15, revealed the Brief Interview for Mental Status (BIMS) score was a ten (10) out of fifteen (15), indicating the resident was moderately cognitively impaired and interviewable. Further review of the MDS revealed the facility has assessed the resident as needing total assistance of two (2) staff with transfers.

Record review of the Comprehensive Care Plan for falls, date initiated on 07/30/13 and target date of 07/28/15 revealed the resident required total assistance with transfers and is totally dependent on staff for transfers. Record review of the CNA care plan, dated 06/2015, revealed assist of two

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F 282. Continued From page 2
(2) with gait belt.

Record review of the Comprehensive Care Plan for skin tears, dated initiated 03/25/13 with target date of 07/28/15, revealed history of skin care provided to left lower extremities and to use caution during transfers to prevent striking extremities against sharp or hard surfaces.

Interview on 07/07/15 at 3:35 PM, with Licensed Practical Nurse/wound care nurse (LPN) #2 revealed she had been informed that CNA #1 was transferring Resident #1 independently and the resident obtained skin tears on 06/18/15. She investigated on 06/18/15 and found Resident #1 with skin tears and was bleeding to right elbow. On 06/19/15 CNA #2 informed LPN #2 of skin tears and bleeding. She found Resident #1 with skin tears and bleeding on his/her lower leg. CNA #2 admitted to LPN that she self-transferred Resident #1.

Interview was attempted on 07/07/15 at 2:05 PM, with CNA#1 concerning the transfer of Resident #1 on 06/18/15 and skin tear to Resident #1 right elbow, with no returned call.

Interview on 07/07/15 at 1:55 PM, CNA#2 revealed she had observed other CNA's use the same transfer method she used with Resident #1. Resident #1 was the last one to return back to his/her room. Resident #1 was up watching television when she went to his/her room to lay him/her down. She stated the residents' feet were between the foot rests of the wheel chair so she removed the foot rests. She then turned Resident #1 in his/her wheel chair toward the side of the bed and had the resident hug her neck while she grabbed the residents' pants and belt loops. As

F 282
F282 On 7/8-7/10/15, DON and MDS Coordinators observed CNAs conducting transfers of Resident #1 from bed to chair and chair to bed to verify that they were using a two-person lift correctly. Three transfers were observed each day. All transfers were conducted appropriately. The DON also assisted in transfer of Resident #1 on 7/28 to instruct.

The Comprehensive Care Plan and CNA Care Plan for Resident #1 was reviewed for accuracy on 7/8/15, by MDS Coordinators.

All resident Care Plans in the facility were checked and verified by MDS Coordinators to ensure that the CNA Care Plan matched the Comprehensive Care Plan, from 7/8-7/14/15.

After speaking to staff and the DON and MDS Coordinators realized that the facility would benefit from a quick "visual" reference to remind staff that certain residents required an assist of two to transfer. A generic universal symbol for two-person lift was adopted as this visual reference and bright yellow laminated signs of this symbol were placed on the wall at the head of the bed of those residents requiring an assist of two on 7/13/15.

All nursing staff were in-serviced by DON or Social Service Director on 7/8, 7/10-11, 7/13-7/17, 7/21-7/24 on Comprehensive Care Plans, CNA Care Plans, and need to routinely review Care Plans for guidance.

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Resident #1 stood she turned the resident around to sit on the bed. She noticed the resident had a scratch on his/her leg and was bleeding. CNA#2 completed changing the brief and reported the bleeding to the Charge Nurse. She was asked to leave and was terminated due to transferring Resident #1 by herself and not with assist of two (2) as per the care plan.

Interview on 07/07/15 at 3:15 PM, with the Social Services Director/Abuse Coordinator/Training Coordinator revealed the CNA was responsible for reviewing the care plan at the beginning of each shift for any new precautions or changes in care. She further revealed she was contacted with the first incident on 06/18/15, and had intended to complete training with all staff on following the care plans but had not initiated that when the second incident on 06/19/15 occurred. She started her portion of the investigation process on 06/19/15. She stated CNA #1 and CNA #2 were trained on care plans, transfers and abuse prior to this incident.

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

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 interview, record review and review of

F 282

In-service content also included transferring methods acceptable in facility, including two-man assist, gait belt use, hooyer lift use, and sling transfer.

All employees were administered a post-in-service test to demonstrate proficiency.

MDS Coordinators will conduct reviews of resident Care Plans for a minimum of ten residents per day five days per week to ensure Comprehensive Care Plan and CNA Care Plan accuracy for a period of 45 days.

MDS Coordinators will report results of their review to QAPI Committee in their weekly meetings.

Continued compliance will be monitored by Director of Nursing and Administrator in weekly QAPI meetings for a period of 45 days.

F 323

Completed 8/20/15

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the facility's policy, it was determined the facility failed to ensure each resident received adequate supervision and assistance to prevent accidents for one (1) of four (4) sampled residents (Resident #1). The facility failed to conduct re-education with staff in a timely fashion concerning transfers and care plans, as evidenced by after the reported incidence on 06/18/15, when Certified Nursing Assistant (CNA) #1 transferred Resident #1 with assistance of one (1) which resulted in skin tears to the right elbow, then on 06/19/15 CNA #2 again, transferred Resident #1 with assistance of one (1) staff and Resident #1 received skin tears to the left lower leg.

The findings include:

Review of the facility's policy titled "Abuse Prevention Policy and Procedure" not dated, revealed at the beginning of each shift, CNA must read and follow the care plan exactly for each assigned resident. Any questions concerning care should be directed to the nurse or Minimum Data Set Coordinator (MDS). The CNA is responsible for following the care plan and cannot change or ignore a resident's care plan. Resident's care plans that document two (2) assist must have assistance of two (2) staff. Not following the care plan may constitute abuse.

Record review revealed the facility admitted Resident #1 on 02/03/09 with diagnosis of Muscle Weakness, Anxiety, Macular Degeneration, Depression and Parkinson's disease. The Annual Minimum Data Set (MDS) dated 04/27/15, revealed the Brief Interview for Mental Status (BIMS) as ten (10) out of fifteen (15), indicating the resident was moderately cognitively intact and

F323
P323 Director of Nursing observed transfers of Resident #1 from bed to chair and from chair to bed on 7/7-7/10/15 and has assisted with lift of resident on 7/28/15, to verify and instruct lifting procedures.

DON, MDS Coordinators, and LPN D.C. reviewed incident and accident reports for past 90 days to attempt to identify any other resident that may have been involved in a similar incident, but no other residents were identified that may have been affected by this deficient practice.

All nursing staff were in-serviced by DON or Social Service Director on 7/8, 7/10-11, 7/13-17, 7/21-24 on Comprehensive Care Plans, CNA Care Plans, as well as transferring methods acceptable in facility.

Competency established through post-education test and through direct observation by MDS Coordinators.

MDS Coordinators will review Comprehensive Care Plans, fall reports, accident/incident reports, and all orders for residents five days per week to verify care accuracy, as well as to witness care of residents.

Results of MDS Coordinators efforts will be submitted to QAPI Committee in their weekly meetings for a period of 45 days.

Continued compliance will be monitored by the QAPI Committee, Director of Nursing, and Administrator.

Completed 8/20/15

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F 323 Continued From page 5

interview able. Further review of the MDS revealed the facility assessed the resident to be total dependent on staff for transfers and required two (2) person assistance with transfers.

F 323

Record review of the Comprehensive Care Plan for falls, date initiated on 07/30/13 and with target date of 07/28/15 revealed Resident #1 was totally dependent on staff for transfers and required two (2) person assist.

Record review of the CNA care plan, dated 06/2015, revealed assist of two (2) with gait belt.

Interview on 07/07/15 at 2:40 PM, with the MDS Coordinator revealed she checked daily for any changes in the resident's care. She received a fax and a copy of written physician orders and she attended the stand-up meeting for current information and updates for the resident's care plan. She further revealed she made all the changes to the Comprehensive Care Plan. Listed under Resident #1's Comprehensive Care Plan for falls, revealed transfers were total assist, which meant assist of two (2) staff.

Interview on 07/07/15 at 3:15 PM, Social Services Director/Abuse Coordinator/Training Coordinator revealed the CNA was responsible for reviewing the care plan at the beginning of each shift for any new precautions or changes in care. She further revealed she was contacted with the first incident on 06/18/15, when CNA #1 transferred Resident #1 independently resulting in the resident obtaining a skin tear, at the end of second shift. She contacted the Director of Nursing (DON) and was instructed to wait until morning to start her part of the investigation. She started her portion of the investigation process on

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06/19/15 and had not started the re-education of staff concerning the care plan and transfers when CNA #2 transferred Resident #1 by assistance of one (1) on second shift and resulted in skin tears to the leg. The re-education of staff started after the 2nd incident with second and third shifts on 06/19/15 and was completed with first shift on 06/20/15. The re-education of staff should have started on 06/18/15.

Several attempts were made to contact CNA #1, who no longer worked at the facility with no returned call.

Interview on 07/07/15 at 1:55 PM, CNA#2 revealed has had her resident list for three (3) weeks and knew her residents well. She had observed other CNA's use the same transfer method she used with Resident #1. Resident #1 was the last one to return back to his/her room. Resident #1 was up watching television when she went to his/her room to lay him/her down. Then CNA #2 noticed the residents' feet were between the foot rests of the wheel chair so she removed the foot rests. She then turned Resident #1 in his/her wheel chair toward the side of the bed and had the resident hug her neck and grabbed the residents' pants and belt loops. As Resident #1 stood she turned the resident around to sit on the bed. CNA #2 took off the residents' leg selves and changed his/her brief. She noticed the resident had a scratch on his/her leg and was bleeding. CNA#2 completed changing the brief and reported to the Charge Nurse the scratch. She was asked to leave and was terminated due to transferring Resident #1 by herself and not with assist of two (2).

The Administrator and the Director of Nursing

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F 323 Continued From page 7
(DON) were neither one at the facility to interview.
The Social Service Director was in charge of the
facility in their absence.

F 323