

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

PRINTED: 05/05/2011
 FORM APPROVED
 OMB NO. 0938-0391

RECEIVED

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 04/06/2011
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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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F 000	INITIAL COMMENTS	F 000		
F 225 SS-D	<p>A standard health survey was conducted on April 4-6, 2011. Deficient practice was identified with the highest scope and severity at "F" level.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and</p>	F 225	<p>F 225 Resident #3 skin tear was treated and is healing well.</p> <p>Resident #14 expired on 11/10/10.</p> <p>A thorough investigation was conducted Beginning 4/6/11, and ending 4/11/11, by the Director of Social Services, the Director of nursing, and the Assistant Director of nursing in an attempt to determine the source of the skin tear. All nursing staff, including nurses, SRNAs, KMAs, and the wound nurse were interviewed at length, but we were unable to determine the source of the skin tear.</p> <p>All residents in the facility have been examined for unexplained injuries by the DON, ADON, Jamie Pearce, LPN, and Sherry Thomas, RN on 4/7, 4/8, and 4/11. No injuries of unknown source were identified.</p> <p>In-services were conducted by the Director Of Nursing and Assistant Director of Nursing with all SRNAs and all nurses (LPN and RN) on 4/7, 4/8, 4/11, 4/12, 4/13, and 4/14, pertaining to the necessity of proper documentation of injuries of unknown source, reporting requirements, and update on Abuse identification and reporting requirements.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Michael J. Fisher TITLE: *Administrative* (X6) DATE: *5/6/11*

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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F 225	<p>Continued From page 1</p> <p>certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined the facility failed to thoroughly investigate and report injuries of unknown origin to the required State Agencies for two of seventeen sampled residents. Residents #3 and #14 were observed to have skin tears. The facility could not provide documentation the incidents had been investigated or reported to the State Agencies as required.</p> <p>The findings include:</p> <p>A review of the facility's policy (undated) titled Abuse Prevention Policy and Procedure revealed the residents are to be observed for signs of physical abuse such as non-explained injuries. The policy further revealed the facility would investigate incidents and allegations in a timely and thorough manner. The policy also revealed the facility was responsible for making reports to regulatory agencies within 24 hours after an allegation of abuse, and the results of their investigation within five days of the alleged occurrence.</p> <p>1. A review of the medical record for resident #3 revealed the resident had been admitted to the facility on August 9, 2007, with diagnoses of Alzheimer's, Iron Deficiency Anemia, Osteoarthritis, and Osteoporosis. The medical</p>	F 225	<p>F 225 (con't)</p> <p>Injuries of unknown source are reported to The Director of Nursing and Assistant Director of Nursing on Incident/Accident report form. Social Services Director is then notified immediately if investigation is required. All injuries of unknown source with any potential for abuse are immediately reported to the Administrator.</p> <p>All reports pertaining to injuries of unknown source are reported to the CQI Committee during the weekly meeting for monitoring for compliance.</p> <p>F 225 4/15/11</p>		

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F 225	<p>Continued From page 2</p> <p>record further revealed the resident received hospice services.</p> <p>A review of the current Minimum Data Set (MDS) for resident #3 dated January 24, 2011, revealed the resident required the total assistance of two persons to turn and reposition the resident in bed.</p> <p>Observation of resident #3 on April 4, 2011, at 12:35 p.m., revealed the resident lying in bed on the resident's right side. The resident's bed had all four side rails up and the rails were covered with mesh. The resident did not respond when the resident's name was spoken. A skin tear with steri-strips was observed on the resident's right upper arm.</p> <p>A nurse's note written on April 3, 2011, at 1:10 a.m., by Licensed Practical Nurse (LPN) #8 revealed a skin tear was observed to the resident's right upper arm. Based on documentation, the skin tear measured 3.5 centimeters in length and 1 centimeter in width.</p> <p>An interview conducted with LPN #8 on April 6, 2011, at 1:22 p.m., revealed the LPN had found a bandage on resident #3's right upper arm at approximately 1:10 a.m. on April 3, 2011. The LPN further stated he/she was told by State Registered Nursing Assistant (SRNA) #7 and SRNA #8 that the resident had blood coming from somewhere because one of the SRNAs had gotten blood on his/her sweater. Upon assessment, LPN #8 stated he/she found the blood coming from a dressing on the resident's right upper arm. The LPN stated he/she removed the dressing and observed a skin tear. The LPN stated he/she was unaware how the skin tear</p>	F 225		
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F 225	<p>Continued From page 3</p> <p>happened. The LPN further stated the resident was extremely impaired cognitively and was unable to tell how the skin tear occurred. The LPN further stated he/she had notified the resident's daughter and the physician of resident #3.</p> <p>An interview conducted with the Director of Nursing (DON) on April 6, 2011, at 2:15 p.m., revealed resident #3's skin tear was an injury of unknown origin. The DON stated he/she did not do an investigation of the incident. The DON stated he/she had not felt it was necessary to notify State Agencies for skin tears unless there was bruising or something else to indicate possible abuse.</p> <p>2. A review of the closed record for resident #14 revealed the resident was admitted to the facility on January 3, 2008, and expired at the facility on November 10, 2010. Resident #14's admitting diagnoses included a history of Left Cerebral Vascular Accident, Right Hemiparesis, and a history of Seizures.</p> <p>The MDS (Minimum Data Set) for resident #14 dated September 5, 2010, revealed the resident required total assistance with activities of daily living.</p> <p>A review of the nurse's notes for August 27, 2010, at 8:30 a.m., revealed resident #14 had been observed by staff to have a skin tear to the right forearm. The documentation also revealed the physician and responsible party were notified. An incident report on file for the skin tear revealed no documentation related to the origin of the skin tear.</p>	F 225		

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F 225	<p>Continued From page 4</p> <p>In addition a review of the nurse's notes for October 7, 2010, at 9:00 p.m., revealed the resident was observed to have a skin tear of unknown origin on the left forearm.</p> <p>Interview with the Director of Nursing on April 6, 2010, at 3:50 p.m., revealed there was not an incident report related to the skin tear and it was not on the facility's tracking system for investigations for skin tears.</p> <p>Interview with the Director of Nursing on April 6, 2010, at 4:50 p.m., revealed the CQI (Committee for Quality Improvement) meets every week to review incident reports on falls, medication errors, skin tears, and bruises. According to the DON, the team looks at the reports and attempts to determine the cause of the incidents. The DON stated if there was a skin tear with excessive bruising, an investigation would be conducted, and a report would be made to the appropriate agencies. However, according to the DON, if there was not excessive bruising observed with a skin tear, a report was not made. The DON further stated that the failure to report skin tears of unknown origin was not in accordance with the facility policy.</p>	F 225		
F 323 SS-E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p>	F 323		

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F 323	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the residents' environment remained as free from accident hazards as possible. Observation during the environmental tour revealed the facility failed to ensure Lemon Basil Shower Gel, Efferdent Denture Tablets, Blackberry Vanilla Milk Bath, Body Sense Non Acetone Nail Polish Remover, and Bergamot Vanilla Body Mist were secured/locked and not accessible to residents. All contained labels stating to keep out of the reach of children. The findings include: A review of the facility's policy titled Resident Room Safety Policy, containing no date, revealed nail polish, polish removers, aerosol cans, hair spray, deodorant, etc., are not allowed in the residents' rooms. Observation during the environmental tour on April 4, 2011, at 6:30 p.m., revealed a bottle of Body Sense non-acetone nail polish remover and a bottle of Bergamot Vanilla Body Mist sitting on the resident's sink in resident room 10. Both bottles contained a label stating to keep out of reach of children and could be harmful if swallowed. Further observation on April 5, 2011, at 8:30 a.m., revealed a bottle of Lemon Basil Shower Gel, a box of Efferdent denture tablets, and a bottle of Blackberry Vanilla Milk Bath. All containers	F 323	F 323 All personal/potentially harmful items found were removed from all resident rooms in the facility immediately. Shelving has been installed in resident bathrooms at a high level and personal/potentially harmful items have been placed on these shelves or in resident closets for storage. In-services have been conducted by the Director of Nursing and Assistant Director of Nursing on 4/7, 4/8, 4/11, 4/12, 4/13, and 4/14 with all staff in all departments to discuss storage of potentially harmful items in resident rooms. Charge Nurses, SRNAs, and KMAs will monitor daily for continued compliance. Social Services Director and Maintenance Supervisor will monitor on a weekly basis in their environmental inspections. Results of inspections will be reported to CQI Committee in weekly meetings for compliance. F 323 4/15/11	

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F 323	Continued From page 6 contained a label stating to keep out of reach of children and could be harmful if swallowed. An interview conducted with the A Wing Charge Nurse (CN) on April 4, 2011, at 6:35 p.m., revealed there were two residents on the A Wing that wandered and that could wander into the resident rooms and, as a result, would have access to the substances. The CN further revealed residents were not supposed to have nail polish remover and body sprays in the rooms. An interview conducted with the Director of Nursing (DON) of the facility on April 6, 2011, at 2:15 p.m., revealed residents were permitted to have personal items such as spray deodorant, hairspray, shampoo, body wash, lotions, and perfumes in the resident's room. However, the DON stated the residents were not permitted to have potentially hazardous chemicals left unattended in resident rooms.	F 323			
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide food at the proper temperature for one of seventeen sampled residents. Resident #1's dinner meal tray was left sitting on the resident's	F 364			

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F 364	<p>Continued From page 7</p> <p>overbed table for twenty minutes without evidence of the staff's attempt to feed the resident.</p> <p>The findings include:</p> <p>Resident #1 was admitted to the facility on September 29, 2008, with medical diagnoses of Hypertension, Spinal Stenosis, and Dementia illness with associated behaviors. Record review of the quarterly Minimum Data Set (MDS) dated March 28, 2011, revealed resident #1 was assessed to require extensive assistance with eating and required one person to assist the resident to eat.</p> <p>An observation conducted on April 4, 2011, at 6:45 p.m., revealed resident #1 lying in bed with eyes closed when Certified Nurse Assistant (CNA) #7 entered the resident's room with a dinner tray, sat the tray on the overbed table, and left the resident's room. Additional observation on April 4, 2011, at 7:00 p.m., revealed resident #1 lying in bed with eyes closed, and the dinner meal tray continued to remain, untouched, on the overbed table.</p> <p>An interview conducted on April 4, 2011, at 6:45 p.m., with CNA #7 confirmed resident #1 was required to be fed by the facility staff. CNA #7 stated he/she was assigned to work the dining room and had not been assigned to feed the resident. According to CNA #7, CNA #1 had been assigned to feed resident #1 and had been informed that the meal tray had been delivered to resident #1.</p> <p>An interview conducted on April 4, 2011, at 6:55</p>	F 364	<p>F 364 Resident #1 received a fresh tray on 4/4/2011, with food served at proper temperatures, and was properly fed by a SRNA.</p> <p>The meal service had been completed, and all residents had been fed. No additional residents were identified that may have been affected by the deficient practice.</p> <p>Dietary staff and SRNA's were in-serviced by the Registered Dietitian and Certified Dietary Manager on 4/4, 4/7, 4/21, and 4/27, regarding proper serving temperatures, food-borne illnesses, proper tray delivery and preparation to residents requiring assistance, and change in procedures designed to address this particular issue.</p> <p>In order to avoid a similar occurrence in the future we have redistributed the resident feeder trays on the delivery carts so that fewer feeder trays are delivered on each cart. This will enable SRNA's to feed residents in a timely manner with food at proper temperatures.</p> <p>Compliance to be monitored by CDM and Reported to CQI Committee in their weekly Meetings.</p> <p style="text-align: center;">F 364 4/28/11</p>		

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F 364	<p>Continued From page 8</p> <p>p.m., with CNA #1 confirmed he/she had been responsible to feed resident #1. The CNA further stated that he/she had other residents on the unit to feed, and had not been readily available to feed resident #1 at the time the resident's meal tray had been delivered.</p> <p>An interview conducted on April 4, 2011, at 6:50 p.m., with Licensed Practical Nurse (LPN) #1 revealed he/she was responsible for monitoring the CNAs to assure that all residents were fed. However, the LPN reportedly was unaware that resident #1 had not been fed timely.</p> <p>Additional interview conducted on April 5, 2011, at 1:15 p.m., with CNA #8 revealed the meal trays for residents who were fed by the staff should not be taken to the resident's room and left. The CNA added the resident's tray should have been removed from the cart at the time the CNAs were ready to feed the resident.</p> <p>The facility's Dietary Manager (DM) obtained food temperatures on April 4, 2011, at 7:10 p.m., of the food items on resident #1's meal tray. The temperature of the tomato soup was 118 degrees, the mashed potatoes was 107 degrees, the chicken salad was 88.1 degrees, the mighty shake was 55.7 degrees, and the coffee was 97 degrees.</p> <p>Review of the facility's policy titled "Minimum Temperature at Point of Service to Resident" (no date) stated the policy of the facility was to serve food at minimum temperatures which included: creamed soups greater than 130 degrees, mashed potatoes greater than 115-125 degrees, milk less than 45 degrees, and coffee greater</p>	F 364			

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F 364	Continued From page 9 than 150 degrees. An interview on April 4, 2011, at 7:15 p.m., with the DM revealed the food on resident #1's meal tray was not at the proper temperatures for the resident to eat. The DM stated the tomato soup and mashed potatoes were too cold and the mighty shake was too warm. In addition, the DM stated the chicken salad was too warm, and not safe for the resident to eat.	F 364	F 371 The mop and bucket was removed From the kitchen area on 4/4/2011. A new procedure has been established by the Certified Dietary Manager that requires removal from the dietary area and emptying of the mop bucket after each use. The mop-head is then removed from the mop handle and placed in laundry for cleaning, and the mop bucket is placed in outside storage building. This takes place each time the mop is used. Mop water is not allowed to be re-used.	
F 371 SS=F	483.35(i) 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, interview, and record review, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions. A mop bucket filled with dirty water and a wet mop were observed on the kitchen floor in the dishwashing room. The findings include: During the initial tour of the facility's kitchen conducted on April 4, 2011, at 12:10 p.m., observation revealed a mop bucket filled with	F 371	In-services were conducted with dietary Personnel on 4/4, 4/7, 4/14, and 4/27, by The Registered Dietitian and Certified Dietary Manager to cover the new Policy with all employees. Compliance will be monitored by the Certified Dietary Manager and reported to the CQI Committee in the weekly meetings. F 371 4/28/11	

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F 371	Continued From page 10 brown-colored water and a wet mop lying on the floor in the dishwashing room. An interview conducted on April 4, 2011, at 12:15 p.m., with the Dietary Manager (DM) revealed all cleaning supplies, including the mop and mop bucket, should be put in the kitchen's storage closet when not in use. In addition, the DM acknowledged in interview that it would be an unsanitary practice to leave the dirty mop and mop bucket out in the kitchen area while the lunch meal is served. Review of the facility's policy on sanitation (no date) revealed the policy failed to address the kitchen area.	F 371		
F 441 SS=E	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	F 441	F 441 In-services have been conducted on Infection Control Policy by the Director of Nursing and Assistant Director of Nursing on 4/7, 4/8, 4/11, 4/12, 4/13, and 4/14 with all SRNAs, KMAs, and Nurses regarding cross-contamination and need to follow Universal Precautions, continual hand-washing requirements, and appropriate preparation for resident contact. Director of Nursing, Assistant Director of Nursing, and Certified Dietary Manager have monitored meal passage on 4/7, 4/8, 4/11, and 4/12, to re-direct employees and to further educate during activity associated with meal service. DON, ADON, and CDM, as well as all Charge Nurses will continue to monitor employees and any employees violating this procedural policy will be redirected and Rr-educated. Continued compliance will be monitored by the CQI Committee and violations will be reported in weekly meetings. F 441 4/15/11	

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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 04/06/2011
NAME OF PROVIDER OR SUPPLIER DOVER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 112 DOVER DRIVE GEORGETOWN, KY 40324		
(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 11</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</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 staff washed their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Staff was observed not washing/sanitizing hands during the evening meal service on April 4, 2011, and during the noon meal service on April 5, 2011.</p> <p>The findings include:</p> <p>1. Observation of the evening meal served in the sun porch dining area on April 4, 2011; at 5:56 p.m., revealed State Registered Nursing Assistant (SRNA) #5 sanitized hands and then touched his/her hair before setting up a tray for a</p>	F 441			

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F 441	<p>Continued From page 12</p> <p>resident. After the tray was set up the SRNA touched his/her hair again and retrieved another tray from the cart. SRNA #5 did not wash/sanitize hands until prompted by another SRNA to wash his/her hands</p> <p>An interview conducted with SRNA #5 on April 4, 2011, at 6:00 p.m., revealed the SRNA's hair would drop down into the SRNA's face and the SRNA would reposition the hair away from his/her face. The SRNA acknowledged in interview that he/she was required to wash/sanitize hands between trays and after touching his/her hair, and stated that he/she had forgotten to wash/sanitize his/her hands as required.</p> <p>2. Observation of the noon meal service was conducted on April 5, 2011, at 12:35 p.m. Observation of SRNA #6 during the meal service revealed the SRNA touched his/her eyes/face, retrieved a resident's tray from the meal cart, transported the tray to the resident's room, and set the tray up for the resident without washing/sanitizing his/her hands. The SRNA was also observed to open drinks for the resident and place straws in the resident's drinks without washing or sanitizing hands.</p> <p>An interview conducted with SRNA #6 on April 5, 2011, at 12:35 p.m., revealed the SRNA had not considered and had failed to wash his/her hands after touching his/her eyes/face prior to delivery and setup of the meal tray for the resident.</p> <p>3. An observation of the noon meal on April 5, 2011, at 12:35 p.m., revealed SRNA #3 touching the right side of the face, lifting a resident's tray from the cart, carrying the tray to the resident's</p>	F 441			

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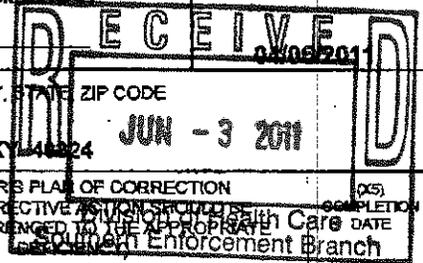
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2011	
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F 441	<p>Continued From page 13</p> <p>room, pulling the tray table to the bedside, and setting the tray up for the resident without washing her/his hands. The SRNA left the room without washing/sanitizing his/her hands and proceeded to go to the cart.</p> <p>An interview with SRNA #3 on April 5, 2011, at 12:40 p.m., revealed the SRNA had failed to wash/sanitize his/her hands during the meal and between residents. The SRNA stated he/she had never been told to wash hands between residents.</p> <p>4. An observation of the noon meal on April 5, 2011, between 12:30 p.m. and 12:45 p.m., revealed SRNA #4 had failed to wash/sanitize his/her hands between meal tray delivery to residents in the sun room and the delivery of meal trays to residents on the B Unit of the facility.</p> <p>An interview was conducted with SRNA #4 on April 5, 2011, at 1:00 p.m. The SRNA acknowledged that he/she had failed to wash/sanitize his/her hands prior to removing meal trays from the carts, and prior to delivering/setting up the meal trays for the residents in the sun room and in the resident rooms of the facility.</p> <p>5. Observation of the noon meal service on April 5, 2011, at 12:38 p.m., revealed SRNA #2 touched his/her hair and proceeded to deliver a tray to a resident without washing his/her hands. The SRNA then proceeded to touch his/her hair again, retrieve a meal tray from the cart, and set the tray up for another resident without washing/sanitizing his/her hands.</p>	F 441		

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F 441	Continued From page 14 An interview conducted with SRNA #2 on April 5, 2011, at 1:20 p.m., revealed the SRNA was aware he/she should have washed his/her hands after touching his/her hair. The SRNA further revealed he/she should have washed/sanitized hands between residents. The SRNA stated he/she was nervous.	F 441			

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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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<p>K 000 INITIAL COMMENTS</p> <p>TYPE OF STRUCTURE: 1977 One-story unprotected frame Type V (200) with a complete automatic sprinkler system throughout.</p> <p>A life safety code survey was initiated and concluded on April 6, 2011. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). Dover Manor was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>K 025 SS=F NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers with at least a one-half hour fire resistance rating as required. This deficient practice affected six of six smoke</p>	<p>K 000</p> <p>K 025 This deficiency is related to a structural aspect of the building and all residents were affected by the deficient design/original construction of the smoke barriers in the facility. New smoke barriers will be constructed that are in compliance with current Life Safety Code Standards.</p> <p>All resident in the facility were affected by the deficient design/construction of the original smoke barriers in the facility. New smoke barriers shall be constructed that are in compliance with current Life Safety Code Standards.</p> <p>Tom Burke, AIA, with Stewart Architecture has been retained to evaluate the design of the facility and to develop a construction plan that will meet current Life Safety Code standards.</p> <p>Mr. Burke has inspected the facility and measured the locations of those smoke barriers acceptable to the Life Safety Code Inspector and has proposed a construction plan that meets the current Life Safety Code Standard. Mr. Burke has discussed this matter with LSC Inspector Glen Martin, and separately with Bob Andrews. Mr. Burke has proposed a construction plan to build</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Michael J. ...* TITLE: *Administrator* (X6) DATE: *6/11*

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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PRINTED: 05/24/2011
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2011
NAME OF PROVIDER OR SUPPLIER DOVER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 112 DOVER DRIVE GEORGETOWN, KY 40324	
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K 025	Continued From page 1 compartments, staff, and all the residents. The facility has the capacity for 85 beds with a census of 78 on the day of the survey. The findings include: During the Life Safety Code survey on April 6, 2011, from 10:20 a.m. to 10:45 a.m., with the Director of Maintenance (DOM), an inspection of the fire/smoke barrier wall above the ceiling in resident room 20 revealed the fire/smoke barrier wall in the attic was approximately 25 feet away from the cross-corridor fire doors adjacent to resident room 20. An interview with the DOM on April 6, 2011, at 10:20 a.m., revealed the DOM was not aware the fire doors in the corridor should line up with the fire/smoke barrier wall in the attic. Fire/smoke barrier walls must be properly maintained to prevent fire and smoke from spreading to other areas of the facility. Three other fire/smoke barrier walls in the attic area were observed not to be in line with the cross-corridor fire door assemblies in the A and B wings of the facility. These cross-corridor doors were marked as fire doors. The facility's smoke compartment evacuation plan stated that staff should transfer occupants of the building past the fire doors for protection in case of fire. A fire/smoke barrier wall assembly in the attic area next to the chapel was observed to be missing an approximate 2 by 8 foot piece of sheetrock material. Reference: NFPA 101 (2000 Edition). 8.3.2* Continuity. Smoke barriers required by this Code shall be	K 025	K 025 (con't.) two (2) additional smoke barriers in the facility, add smoke doors to the A wing corridor, and to add closers to several doors inside the facility. The plan also involves relocating the "Exit" light from the existing smoke doors found not in compliance, to the new doors, and to tie the new smoke doors in to the existing fire alarm system. Closers and magnetic latches will also be added to the new smoke doors. A draftsman with Stewart Architecture is transferring the original construction drawings from the facility to a Computer Assisted Design program, and the finished construction plan depicting the work to be completed will be emailed in PDF form to Mr. Martin and Mr. Andrews for approval. If the plan is acceptable we will immediately begin locating a contractor and expedite the completion of the required work. The work in question will be completed by an independent contractor not affiliated with the facility. Once begun, work will continue without interruption until completed. Given the need to locate an acceptable contractor, and the extent of the work involved, we anticipate a time period of approximately 60 days to complete the work necessary to be in compliance, and we are requesting a waiver for the period required.	

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K 025	Continued From page 2 continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. 19.3.7.1 Smoke barriers shall be provided to divide every story used for sleeping rooms for more than 30 patients into not less than two smoke compartments. The size of any such smoke compartment shall not exceed 22,500 ft ² (2100 m ²), and the travel distance from any point to reach a door in the required smoke barrier shall not exceed 200 ft (60 m). Exception No. 1: Where neither the length nor width of the smoke compartment exceeds 150 ft (45 m), the travel distance to reach the smoke barrier door shall not be limited.	K 025	K 025 (con't) The 2' by 8' section of smoke barrier noted as missing during the LSC Survey has been replaced and the smoke barrier has been inspected and found to be intact. Smoke barriers shall be inspected on a quarterly basis to ensure continued integrity of the barrier, and shall be inspected after any work has been completed by employees or contractors that may have the potential to disturb the smoke barriers. Inspections shall be made by Director of Maintenance and reported to Administrator and CQI Committee. Completed 8/1/11	
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13	K 074		

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K 074	<p>Continued From page 3</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3), 10.3.4, 19.7.5.3</p> <p>This STANDARD is not met as evidenced by. Based on observation and interview, the facility failed to ensure that window curtains had documentation showing a fire resistant rating as required by NFPA standards. This deficient practice affected one of six smoke compartments, staff, and approximately six residents. The facility has the capacity for 85 beds with a census of 78 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on April 6, 2011, at 8:55 a.m., with the Director of Maintenance (DOM), window curtains located in the front lobby were observed not to have a label indicating they were flame resistant. An interview with the DOM on April 6, 2011, at 8:55 a.m., revealed the DOM thought resident room curtains were the only curtains that had to be fire rated.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.7.5.1* Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies shall be in accordance with the</p>	K 074	<p>K 074 The draperies that were not fire-rated have been removed from the lobby area and from the facility. When replaced new draperies will be documented as fire-rated.</p> <p>All additional window treatments in the facility have been inspected and verified for fire rating.</p> <p>K 074 4/15/11</p>	

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K 074	Continued From page 4 Fire-retardant coatings shall be maintained to retain the effectiveness of the treatment under service conditions encountered in actual use. 10.3.1* Where required by the applicable provisions of this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.	K 074			
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on an interview, the facility failed to maintain the generator set by NFPA standards. This deficient practice affected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 85 beds with a census of 78 on the day of the survey. The findings include: During the Life Safety Code tour on April 6, 2011, at 10:15 a.m., an interview with the Director of Maintenance (DOM) at the generator transfer	K 144	K 144 Manual testing of transfer Switch has been added to form used for documentation of monthly generator testing and verification of operation. Results of testing will be reported to the CQI Committee at their weekly meetings. Continued compliance will be monitored by CQI Committee. K 144 4/8/11		

PRINTED: 04/20/2011
 FORM APPROVED
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K 144	Continued From page 5 switch revealed the DOM was not aware the generator transfer switch was required to be tested and logged on a monthly basis. Monthly testing ensures this switch remains operational. Reference: NFPA 110 (1999 Edition). 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.	K 144		
K 147 SS=D	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, the facility failed to keep adequate working space around electrical panel boxes. The findings include: During the Life Safety Code tour on April 8, 2011, at 10:10 a.m., with the Director of Maintenance (DOM), electrical panel boxes and the sprinkler system riser located in the facility mechanical room were observed to be inaccessible due to the room being used for storage. An interview with the DOM on April 6, 2011, at 10:10 a.m., revealed the DOM discouraged staff from utilizing the room for storage due to safety and maintenance	K 147	K 147 Items stored in electrical area have been removed. Electrical panels are unobstructed. Signage has been placed on the door leading to the electrical equipment room advising employees that items are not to be stored in this area. In-services have been held with all employees on 4/7, 4/8, and 4/12 by the Maintenance Supervisor and independently by the Director of Nursing instructing employees that the electrical panels are not to be obstructed. Electrical equipment room is monitored daily by Maintenance Supervisor and all maintenance staff. Violations will be reported to CQI Committee in weekly meetings. K 147 4/12/11	

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K 147	Continued From page 6 issues. The facility staff continued to use the room for storage. Reference: NFPA 70 (1999 Edition). 110.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded.	K 147		
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop a fire watch policy to ensure the safety of occupants of the building in case of	K 154	K 154 A new Fire Watch Policy, Procedure, and Log has been created and placed in use. All system outages shall trigger a fire watch and log shall be completed at that time. In-services have been conducted by the Maintenance Supervisor on 4/14, and 4/15 with the maintenance staff and all other supervisory personnel in the facility pertaining to the new policy. Compliance shall be monitored by the Administrator and Maintenance Supervisor. Violations shall be reported to the CQI Committee. K 154 4/15/11	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2011
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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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K 154	<p>Continued From page 7</p> <p>automatic sprinkler system failure. This deficient practice affected six of six smoke compartments, staff, and all of the residents. The facility has the capacity for 85 beds with a census of 78 on the day of the survey.</p> <p>The findings include:</p> <p>During the life safety code tour on April 5, 2011, at 12:05 p.m., a review of facility policies revealed the facility failed to develop a fire watch policy to ensure the safety of occupants of the facility in the event of a failure of the automatic sprinkler system.</p> <p>An interview with the Director of Maintenance (DOM) revealed the DOM was not aware the facility was required to have a fire watch policy in place in the event the building's automatic sprinkler system failed. The DOM stated the DOM had access to life safety code requirements but was not very familiar with the requirements.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop a fire watch policy to ensure the safety of occupants of the building in case of fire</p>	K 154	<p>K 155 A new Fire Watch Policy, Procedure, and Log has been created and placed in use. All system outages shall trigger a fire watch and log shall be completed at that time.</p> <p>In-services have been conducted by the Maintenance Supervisor on 4/14, and 4/15 with the maintenance staff and all other supervisory personnel in the facility pertaining to the new policy.</p> <p>Compliance shall be monitored by the Administrator and Maintenance Supervisor. Violations shall be reported to the CQI Committee.</p> <p>K 155 4/15/11</p>	
K 155 SS=F		K 155		

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K 155	<p>Continued From page 8</p> <p>alarm failure. This deficient practice affected six of six smoke compartments, staff, and all of the residents. The facility has the capacity for 85 beds with a census of 78 on the day of the survey.</p> <p>The findings include:</p> <p>During the life safety code tour on April 5, 2011, at 12:05 p.m., a review of facility policies revealed the facility failed to develop a fire watch policy to ensure the safety of occupants of the facility in the event of a failure of the building's fire alarm system. An interview with the Director of Maintenance (DOM) revealed the DOM was not aware the facility was required to have a fire watch policy in place in the event the building's fire alarm system failed. The DOM stated the DOM had access to life safety code requirements but was not very familiar with the requirements.</p>	K 155		
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