

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

PRINTED: 06/27/2013
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 06/14/2013
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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 A Recertification Survey was initiated on 06/11/13 and concluded on 06/14/13, with deficiencies identified at the highest scope and severity of a "D".	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		

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JUL - 7 2013
BY: _____

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Michael J. ...* TITLE: *Administrator* (X6) DATE: *7/7/13*

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 278 : Continued From page 1

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 accuracy of assessments for three (3) of seventeen (17) sampled residents who had sustained falls (Residents #7, #10 and #4)

The findings include:

Review of the facility's policy titled, "Resident Assessment Instrument (RAI)/Minimum Data Set (MDS)", dated 04/12, revealed the purpose was to consistently and accurately gather information regarding resident needs and strength, which provided the foundation for an individualized interdisciplinary plan of care.

Interview with MDS Coordinator #1, on 06/12/13 at 02:20 PM, revealed MDS coordinators try to attend morning meetings to gather information for the RAI/MDS. MDS Coordinator #1 stated optimally the nurses should come and inform MDS coordinators of falls. MDS Coordinator #1 revealed there was a "Falls" tab in the residents' charts, where falls were documented and 24 (twenty-four) monitoring sheet completed.

Interview with Licensed Practical Nurse (LPN) #1, on 06/13/13 at 09:00 AM, revealed documentation of residents' falls in the MDS binder, utilizing the Fall Logs document as well as performing 24 hour monitoring of residents.

Interview with Registered Nurse (RN) #1 and LPN #2, on 06/13/13 at 02:35 PM, revealed falls of

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No corrective action was required for the affected residents. The MDS in each case had been transmitted and modifications are not possible.

The Fall Log and residents MDS were audited by MDS Coordinators and LPN Devonne Cowan on 6/14, 6/15, 6/17, and 6/18 and no additional discrepancies involving other residents were found.

A new Fall Book has been created for each for, and is kept on, each wing. It contains the "Fall Accident report forms. When a fall takes place the Nurse on duty notes the occurrence on the Fall Accident Report form and this form is placed in the Fall Book.

The Fall Book is checked daily by MDS Coordinators and occurrences are captured.

All falls are to be reviewed in weekly CQI Committee meetings and completeness of reports and continuity of information to be monitored by MDS Coordinators and DON.

The Fall Book contains the Fall Accident Report form and the fall Log, which are separate forms. Each fall is noted on this log and the entire Investigative result is noted on the Fall Accident Report form.

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Completed 6/20/2013

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residents are logged into the Fall Log in the MDS binder in the nursing station. They also revealed incident reports and fall reports should also have been completed.

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1. Record review revealed the facility admitted Resident #7 on 03/22/12 with diagnoses which included Personal History of Falls, Abnormality of Gait, Lack of Coordination, and Alzheimer's disease. Further record review revealed a nurse's note, dated 11/23/12 at 7:00 PM, that noted Resident #7 was found by staff, sitting on the floor. Another nurse's note, dated 04/23/13 at 11:15 AM, revealed Resident #7 was found lying on the grass outside the facility.

Review of Falls Log, in MDS binder in nursing station, revealed documentation of a fall for Resident #7 on 11/23/12 at 3:30 PM as well as 04/23/13 at 11:15 AM.

Review of Resident #7's Quarterly MDS, dated 02/10/13, revealed no falls recorded for this resident during this assessment period. Additional review of Quarterly MDS, dated 05/13/13, revealed no falls recorded for this resident during the assessment period.

Interview with MDS Coordinator #2, on 06/13/13 at 2:00 PM, revealed a fall should have been recorded for Resident #7 Quarterly MDS, dated 02/10/13, as well as Quarterly MDS, dated 05/13/13.

2. Record review revealed the facility admitted Resident #10 on 11/20/12 with diagnoses which included Osteoporosis. Further review revealed a nurse's note, dated 03/20/13 at 6:00 PM, which

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noted Resident #10 was found on the floor in bathroom. Additional review revealed documentation of a fall, dated 04/24/13 at 4:15 PM, that Resident #10 was found on the floor in bedroom.

Review of the Falls Log, in the MDS binder in the nursing station revealed documentation of a fall for Resident #10 on 03/20/13 at 6:00 PM as well as another recorded on 04/24/13 at 4:15 PM.

Review of Resident #10's Quarterly MDS, dated 05/25/13, revealed Resident #10 documented as having only 1 (one) fall during this assessment period.

Interview with MDS Coordinator #2, on 06/13/13 at 2:00 PM, revealed a fall should have been recorded for Resident #10 Quarterly MDS, dated 05/13/13, should have shown documentation of 2 (two) falls instead of 1 (one).

3. Record review for Resident #4 revealed the resident was admitted by the facility on 11/23/12 with diagnoses which included Cerebral Vascular Accident, Abnormal Gait, Alzheimer's, Dementing Illness with Associated Behavior Symptoms, and Polio as Child with Left Arm Crippling.

Review of the facility's investigative reports related to falls revealed Resident #4 had three (3) falls since the prior assessment period: on 03/05/13 the resident had a fall when ambulating, on 03/07/13 the resident had a fall when trying to get out of bed, and on 03/08/13 the resident again fell when trying to get out of bed.

Continued review of the 04/24/13 Significant Change MDS Assessment revealed Resident #4

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was assessed as not having had any falls since the prior assessment, Quarterly MDS Assessment dated 03/03/13.

Review of the 04/25/13 Care Area Assessments (CAAs) revealed Resident #4 triggered for falls due to having been assessed as balance and gait were unsteady, was unable to stabilize, ambulates independently, received antipsychotic medications daily, history of polio, and was frequently incontinent of bladder. Further review of the fall CAAs revealed no recent falls were noted.

Interview, on 06/13/13 at 11:00 AM, with MDS Coordinator #1 revealed the falls should have been recorded on the 04/24/13 MDS. She stated when the MDS was updated it was important to know if the resident had fallen because it allowed them to review the reason why and revise the resident's care plan with any ordered intervention or to determine if another intervention was needed.

Interview with the Director of Nursing (DON), on 06/14/13 at 12:05 PM, revealed her expectation of an accurate assessment performed on all residents, including the accurate number of falls. The DON further stated without accurate MDS Assessments, the needs of the residents were not accurately documented.

F 278

F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

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The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on interview, record review and review of the facility's forms and policy, it was determined the facility failed to use the results of assessment to revise the residents comprehensive care plan for two (2) out of seventeen (17) sampled residents (Residents #7 and #10). Both Residents #7 and #10 sustained falls that were not documented on the Minimum Data Set (MDS) Assessments and there was no documented evidence the facility revised the care plans to include interventions for the falls.

The findings include:

Review of facility's policy titled, "Resident Assessment Instrument (RAI)/Minimum Data Set (MDS)", dated 04/12, revealed the purpose was to consistently and accurately gather information

F 279

F 279 Care Plans of the two affected residents were up-dated on 6/18/13, by MDS Coordinators and LPN Devonne Cowan.

MDS and Care Plans for all residents were reviewed on 6/14, 6/17, and 6/18, by MDS Coordinators and LPN Devonne Cowan and no additional deficiencies were noted.

A new Communication Book has been created and placed on each wing. This "MDS Communication Book" functions as a master log that allows nursing staff on the floor to communicate to MDS Coordinators and Care Plan Coordinator unusual and isolated occurrences. MDS Coordinators will review MDS Communication Book daily, check and initial to verify, and include occurrences in Care Plans for residents.

Monitored weekly in CQI meeting by CQI Committee.

Completed 6/20/13

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F 279	<p>Continued From page 6</p> <p>regarding resident needs and strength, which provided the foundation for an individualized interdisciplinary plan of care.</p> <p>1. Record review revealed the facility admitted Resident #7 on 03/22/12 with diagnoses which included Personal History of Falls, Abnormality of Gait, Lack of Coordination, and Alzheimer's disease. Further record review revealed nurse's note, dated 11/23/12 at 7:00 PM, which noted Resident #7 was found by staff, sitting on the floor. Another nurse's note, dated 04/23/13 at 11:15 AM, revealed Resident #7 was found lying on the grass outside the facility. Review of Resident #7's care plan, related to being at risk for falls, revealed the last intervention in place to prevent falls was implemented on 03/22/12.</p> <p>2. Record review revealed the facility admitted Resident #10 on 11/20/12 with diagnoses which included Osteoporosis. Further review revealed nurse's note, dated 03/20/13 at 6:00 PM, which noted Resident #10 was found on the floor in bathroom. Additional review revealed documentation of a fall, dated 04/24/13 at 4:15 PM, when Resident #10 was found on the floor in the bedroom. Review of Resident #10's care plan, related to being at risk for falls, revealed intervention implemented on 05/27/13 was the same as interventions implemented on 11/20/12.</p> <p>Interview with the Director of Nursing (DON), on 06/14/13 at 12:05 PM, revealed interventions were implemented to prevent further falls of the residents but the interventions were not documented on the comprehensive care plans.</p>	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281	<p>Continued From page 7</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's protocol, it was determined the facility failed to ensure services provided by the facility met professional standards of quality by failing to implement the Physician's orders for one (1) of seventeen (17) sampled residents (Resident #5). Resident #5 had diagnoses which included Gastroesophageal Reflux Disease (GERD) (a condition in which the stomach contents (food or liquid) leak backwards from the stomach into the esophagus (the tube from the mouth to the stomach)) and Oropharyngeal Dysphagia (swallowing difficulties). Resident #5 Physician's Orders and plan of care included having the resident sitting up at a ninety (90) degree angle with meals and for two hours after meals. Observation revealed the resident was not at a ninety degree angle for two hours after the morning meal on 06/12/13.</p> <p>The findings include:</p> <p>Review of the facility's protocol: "GERD Precautions", undated, revealed residents with GERD were to be positioned at ninety (90) degrees at meals and for two (2) hours after meals.</p> <p>Interview with the Speech Language Pathologist,</p>	F 281	<p>Residents orders have been revised per Physician's Orders to allow residents to lay down 30 minutes after meals.</p> <p>All residents with GERD precautions were reviewed by the Director of Nursing to verify accuracy of Orders and that Care Plans are accurate, on 6/14, 6/17, and 6/18.</p> <p>CNAs and Nurses have been re-educated by Director of Nursing regarding GERD precautions on 6/14, 6/17, 6/18, 6/21, and 7/3/13.</p> <p>Monitoring to be provided by Charge nurses on a daily basis and by CQI Committee in weekly meetings.</p> <p>Completed 7/5/13</p>	
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F 281	<p>Continued From page 8</p> <p>on 06/14/13 at 9:20 AM and 1:10 PM, revealed residents diagnosed with GERD could belch up stomach contents and re-swallow which could create aspiration issues. She stated treatment was based on diagnostic findings and include lifestyle modification and medication treatment. She further stated strategies included having the resident up at ninety (90) degrees during and after meals. The facility's protocol was to have residents upright for two (2) hours after meals.</p> <p>Review of Resident #5's medical record revealed the resident was admitted by the facility on 08/17/11 with diagnoses which included Oropharyngeal Dysphagia, GERD, Cancer, Progressive Alzheimer's Dementia and was admitted to Hospice on 04/23/13. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 03/22/13, revealed the facility assessed the resident as being severely cognitively impaired. The resident was also assessed as needing total assistance with meals.</p> <p>Review of Physician's Orders, dated June 2013, revealed GERD precautions, elevate the resident to (ninety) degrees at meals and two (2) hours after meals, monitor fatigue with meals, monitor for signs/symptoms of aspiration, reduce bolus size of solids and liquids, alternate solids with liquids, small sips of liquids, and two (2) swallows after each bolus. Continued review of the orders revealed the resident was on a mechanically altered diet, Pureed diet, which required the solid food to be pudding like in consistency.</p> <p>Continued review of the medical record revealed the comprehensive care plan included a plan of care for the resident being at risk for</p>	F 281		

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F 281	<p>Continued From page 9</p> <p>choking/aspiration, initiated 08/31/11, related to a diagnosis of Oropharyngeal Dysphagia which included the intervention to keep the head elevated ninety (90) degrees at meals and for two hours after meals.</p> <p>Observation, on 06/12/13 at 8:45 AM, revealed Resident #5 in bed being assisted with his/her meal and the head of the bed was elevated to approximately ninety (90) degrees.</p> <p>Further observation, on 06/12/13 at 9:20 AM, revealed Resident #5 in bed positioned on his/her back and the bed was elevated at approximately a forty-five (45) degree angle.</p> <p>Interview, on 06/12/13 at approximately 9:45 AM, with Certified Nursing Assistant (CNA) #3 revealed she had assisted Resident #5 with breakfast, but didn't take care of the resident much and was just helping with the meal. She stated the resident was supposed to be sitting up at a ninety (90) degrees during and after meals. She further stated after meals she left the resident's bed up at a ninety (90) degree angle for approximately thirty (30) minutes. The CNA stated if the resident was on GERD precautions it was supposed to be listed on the aide care plan. After reviewing Resident #5's aide care plan, she revealed the precautions were not on the care plan, but should have been. Further interview, with CNA #3, revealed if the precautions were not listed on the care plan, aides may not have been aware of the precautions when assisting the resident with meals.</p> <p>Interview with Registered Nurse (RN) #1, on 06/12/13 at 9:50 AM, revealed Resident #5 had</p>	F 281		
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F 281	<p>Continued From page 10</p> <p>Physician's orders to be up at ninety (90) degrees during meals and two (2) hours after meals because the resident was on GERD precautions to prevent choking and aspirations. She stated they had a list of residents on GERD precautions (Resident #5 was on list), along with the protocols and the list was posted at the nurse station, in the aide care plan book with that resident's aide care plan, and posted on the resident's door. She further stated the GERD precautions was also supposed to be on the aide care plan. After looking in the aide care plan book and observing the back of the resident's door, RN #1 stated they did not include the GERD precaution list with the resident's aide care plan or post it behind the resident's door. RN #1 further stated the aide care plan did not include GERD precautions. Continued interview with RN #1 revealed, they did not follow the facility's process for alerting staff therefore the Physician's order was not followed.</p> <p>Interview with the Director of Nursing (DON), on 06/14/13 at 1:30 PM, revealed Resident #5 had aspiration issues due to Dysphagia and would cough and had clear nasal drainage when he/she ate which were traditional signs of aspiration. The DON stated the GERD protocol precaution to keep the resident at ninety (90) degrees (for meals and two (2) hours after meals) was listed on the care plan and should have been on the aide care plan. She stated she did not know why it was not there to alert staff. She further stated the aide did not normally take care of the resident, but should have kept the resident up per the protocol and the Physician's order.</p>	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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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	
F 282	Continued From page 11 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 observation, interview and record review it was determined the facility failed to ensure services were provided by the facility in accordance with each resident's written Plan of Care for one (1) of seventeen (17) sampled residents (Residents #5). Resident #5's Comprehensive Plan of Care included an intervention of having the resident sitting up at a ninety (90) degree angle with meals and for two hours after meals. Observation revealed the resident was not at a ninety (90) degree angle for two (2) hours after the morning meal on 06/12/13. The findings include: 1. Review of Resident #5's medical record revealed the resident was admitted by the facility on 06/17/11 with diagnoses which included Oropharyngeal Dysphagia, GERD, Cancer, Progressive Alzheimer's Dementia and was admitted to Hospice on 04/23/13. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 03/22/13, revealed the facility assessed the resident as being severely cognitively impaired. The resident was also assessed as needing total assistance with meals. Continued review of the medical record revealed	F 282	Affected residents under GERD precautions Care Plans and CNA Care Plans were reviewed on 6/17 and 6/18 by the Director of Nursing to determine accuracy of Orders. All residents under GERD precautions Care Plans and CNA Care Plans were reviewed on 6/17 and 6/18 by the Director of Nursing to determine accuracy of Orders. CNAs were in-serviced on 6/17, and 6/18 by the Director of Nursing regarding GERD precautions and how to read and understand Care Plan directions pertaining to same. GERD precautions have been posted by the Director of Nursing on 6/17 and 6/18. To be monitored by Charge Nurses daily and CQI Committee in weekly meetings.	Completed 6/20/13	

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F 282	<p>Continued From page 12</p> <p>Resident #5's Comprehensive CarePlan included a plan of care for being at risk for choking/aspiration, initiated 08/31/11, due to a diagnosis of Oropharyngeal Dysphagia. Review of the care plan revealed an intervention to keep the head elevated ninety (90) degrees at meals and for two hours after meals.</p> <p>Observation, on 06/12/13 at 8:45 AM, revealed Resident #5 in bed being assisted with his/her meal and the head of the bed was elevated to approximately ninety (90) degrees.</p> <p>Further observation, on 06/12/13 at 9:20 AM, revealed Resident #5 in bed positioned on his/her back and the bed was elevated at approximately a forty-five (45) degree angle.</p> <p>Interview, on 06/12/13 at approximately 9:45 AM, with Certified Nursing Assistant (CNA) #3 revealed she had assisted Resident #5 with breakfast, but didn't take care of the resident much and was just helping with the meal. She further stated she left the resident's bed up at a ninety degree angle for approximately thirty (30) minutes. The CNA stated if the resident was on GERD precautions it was supposed to be listed on the aide care plan. The CNA further stated Resident #5's aide care plan did not include GERD precautions, but it should have been on the care plan. Further interview, with CNA #3, revealed if the precautions were not listed on the care plan, aides, who assisted with meals, may not have been aware of the precautions.</p> <p>Interview with Registered Nurse (RN) #1, on 06/12/13 at 9:50 AM, revealed Resident #5 had orders to be up at ninety (90) degrees during</p>	F 282		
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F 282 Continued From page 13
meals and two (2) hours after meals because the resident was on GERD precautions to prevent choking and aspirations. She further stated the GERD precautions were supposed to be on the aide care plan, but were not listed.

F 282

Interview with the Director of Nursing (DON), on 06/14/13 at 1:30 PM, revealed the GERD protocol precaution to keep the resident at ninety (90) degrees (for meals and two hours after meals) was listed on the care plan and should have been on the aide care plan. She stated she did not know why it was not there to alert staff. She further stated the aide did not normally take care of the resident, but should have kept the resident up per the protocol and plan of care.

F 309
SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

F 309

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's GERD protocol, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well being for one

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F 309 Continued From page 14
(1) of seventeen (17) sampled residents (Resident #5). Resident #5 had diagnoses of Gastroesophageal Reflux Disease (GERD) (a condition in which the stomach contents (food or liquid) leak backwards from the stomach into the esophagus (the tube from the mouth to the stomach)) and Oropharyngeal Dysphagia (swallowing difficulties). Resident #5 was listed on the facility's GERD Precautions which included the intervention to have the resident up ninety degrees at meals and two (2) hours after meals. In addition, the Resident #5 Physician's Order and Comprehensive Care Plan included this same procedure. However, observation revealed the resident was not at a ninety degree angle for two hours after the morning meal on 06/12/13.

The findings include:

Review of the facility's protocol: "GERD Precautions", undated, revealed residents with a GERD diagnosis were to be positioned at a ninety (90) degrees at meals and for two (2) hours after meals.

Interview with the Speech Language Pathologist (SLP), on 06/14/13, at 9:20 AM and 1:10 PM, revealed residents with GERD can belch up stomach contents and then re-swallow which could create aspiration issues. The SLP stated treatments were based on diagnostic findings and include lifestyle modification and medication treatment. The SLP further stated strategies included having the resident up at ninety (90) degrees during and after meals. She stated the facility's protocol was to have residents upright for two (2) hours after meals.

F 309
F 309 Residents under GERD precautions were reviewed by the Director of Nursing on 6/17 and 6/18, and GERD precautions were listed on the CNA Care Plans.

All residents under GERD precautions Care Plans and CNA Care Plans were reviewed on 6/17 and 6/18 by the Director of Nursing to determine accuracy of Orders. GERD precautions were listed on the CNA Care Plans at that time for all residents.

CNAs were in-serviced on 6/17 and 6/18 by the Director of Nursing regarding GERD precautions and how to read and understand Care Plan directions pertaining to same.

GERD precautions have been posted by the Director of Nursing on 6/17 and 6/18.

To be monitored by Charge Nurses daily and CQI Committee in weekly meetings.

F 309 Completed 6/20/13

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F 309	<p>Continued From page 15</p> <p>Review of the medical chart revealed Resident #5 was admitted by the facility on 08/17/11 with diagnoses which included Oropharyngeal Dysphagia, GERD, Cancer, Progressive Alzheimer's Dementia. The resident was admitted to Hospice on 04/23/13. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 03/22/13, revealed the facility assessed the resident as being severely cognitively impaired. The resident was also assessed as needing total assistance with meals.</p> <p>Review of Physician's Orders, dated June 2013, revealed the following orders: GERD precautions, elevate the resident to (ninety) degrees at meals and two (2) hours after meals, monitor fatigue with meals, monitor for signs/symptoms of aspiration, reduce bolus size of solids and liquids, alternate solids with liquids, small sips of liquids, and two (2) swallows after each bolus. Further review of the orders revealed the resident was on a mechanically altered diet, Pureed diet, which required the solid food to be pudding like in consistency.</p> <p>Continued review of the medical record revealed the resident's Comprehensive Care Plan included a plan for at risk for choking/aspiration, initiated 08/31/11, related to a diagnosis of Oropharyngeal Dysphagia. The plan included the intervention to keep the head elevated ninety (90) degrees at meals and for two hours after meals.</p> <p>Observation, on 06/12/13 at 8:45 AM, revealed Resident #5 was in his/her bed being assisted with his/her meal, by Certified Nursing Assist (CNA) #3, and the head of the bed was elevated to approximately ninety (90) degrees.</p>	F 309		

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F 309 Continued From page 16

F 309

Further observation, on 06/12/13 at 9:20 AM, revealed Resident #5 was in his/her bed and the bed was elevated only at approximately a forty-five (45) degree angle and not at the ninety (90) degree angle required for two (2) hours after meals.

Interview, on 06/12/13 at approximately 9:45 AM, with CNA #3 revealed she had assisted Resident #5 with breakfast, but did not take care of the resident much and was just helping with the meal. CNA #3 stated she was aware the resident was supposed to be sitting up at a ninety (90) degrees during and after meals. CNA #3 stated after meals, she left the resident's bed up at a ninety degree angle for approximately thirty (30) minutes. CNA #3 stated if the resident was on GERD precautions it was supposed to be listed on the aide care plan. She stated, after reviewing aide care plan, GERD precautions were not listed on Resident #5's care plan, but should have been. Further interview, with CNA #3, revealed if the precautions were not listed on the care plan, aides may not have been aware of the precautions when assisting the resident with meals.

Interview with Registered Nurse (RN) #1, on 06/12/13 at 9:50 AM, revealed Resident #5 had orders to be up at ninety (90) degrees during meals and two (2) hours after meals because the resident was on GERD precautions to prevent choking and aspirations. RN #1 stated they had a list of residents on GERD precautions (Resident #5 was on list), along with the protocols posted at the nurse station, in with the resident's aide care plan, and posted on the resident's door. RN #1

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F 309 Continued From page 17
stated GERD precautions were supposed to be listed on the aide care plan. After looking in the aide care plan book and observing the back of the resident's door, RN #1 stated GERD precautions were not listed on the Resident #5's aide care plan and the list of residents on GERD precautions was not with the aide care plan or posted behind the Resident #5's door. Continued interview with RN #1 revealed, they did not follow the facility's process for alerting staff.

F 309

Interview with the Director of Nursing (DON), on 06/14/13 at 1:30 PM, revealed Resident #5 had Dysphagia and had aspiration issues. She stated the resident would cough and had clear drainage, at times, when eating, which were traditional signs of aspiration. The DON stated the aide should have kept the Resident #5 up at ninety (90) degrees for two (2) hours after the meal, per the facility's GERD protocol and care plan, due to high risk of aspiration. The DON further stated the precautions should have been on the aide care plan and they usually put the GERD precaution protocols in with the residents aide care plan. She stated she did not know why it was not there to alert staff.

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

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.

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F 323	Continued From page 18	F 323		
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This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure the residents' environment remained as free from accident hazards as was possible; and each resident received adequate supervision and assistive devices to prevent accidents for one (1) of seventeen (17) sampled residents (Resident #2) and one (1) unsampled resident (Unsampled Resident A).

Resident #2 was assessed and care planned to have an alarm on his/her wheelchair to help prevent falls, but on 06/13/13 the alarm was observed to have been disconnected. In addition, the alarm had no batteries. Observation, on 06/11/13 at 2:40 PM, of the bathroom in room 47 (Unsampled Resident A) revealed no towel rack was in place and the grab bar opposite the toilet was covered with towels.

The findings include:

- Review of the facility's policy and procedure titled "Dover Manor Alarms Policy and Procedure", updated 10/04/11, revealed it was the policy of the facility to perform fall risk assessments on each resident and provide alarms as necessary to decrease the risk of falls. The alarms may consist of personal alarms, pressure alarms, self-release seat belt alarms, or a combination of these (or other alarms that may come available) for safety of the resident.

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F 323	<p>Continued From page 19</p> <p>Review of the medical record for Resident #2 revealed the facility admitted the resident on 09/15/09 with diagnoses which included Forearm Deformity, Right Ankle Fracture, Dementia and Muscle Weakness.</p> <p>Review of the Quarterly MDS, dated 02/10/13 revealed the facility assessed the resident as having past fall history with one (1) fall and no injury. The Brief Interview for Mental Status (BIMS) score was twelve (12) of fifteen (15) indicating the resident had moderate impairment in cognition.</p> <p>Review of a fall assessment for Resident #2, dated 04/14/13 revealed the resident was getting up unassisted to use the restroom and fell.</p> <p>Review of the Physician orders revealed orders dated 04/15/13 for Sensatech Alarm to bed secondary to decreased safety awareness and an order dated 04/21/13 for a Magnetic alarm to wheelchair to alert staff of unassisted transfers.</p> <p>Review of medication orders dated 06/01/13, revealed resident received anti-anxiety Remeron 02/05/13, Zanax 01/02/13, and antidepressant Zoloft 12/24/12. Review of Comprehensive Care Plans, dated 05/15/13 revealed to observe Resident #2 for electrolyte imbalance, dizzy, incoherent, disoriented and drowsy.</p> <p>Review of Physician telephone order dated 06/04/13, D/C magnetic alarm to wheelchair and ordered clarification, Sensatec Alarm to bed and chair.</p> <p>Review of the Alarm tracking form dated</p>	F 323	<p>The resident's alarm was immediately restored to full functioning on 6/13/13.</p> <p>The towel rack was immediately replaced on 6/13/13.</p> <p>All resident alarms were inspected on 6/14, by LPN Devonne Cowan and found to be in order.</p> <p>all towel racks were inspected on 6/17/13, by the Housekeeping Supervisor and any found to be in need of attention were replaced.</p> <p>The alarm checklist was revised on 6/17/13, by the Director of Nursing to include: 1) Alarm Type; 2) Presence of batteries; 3) Alarm function; 4) Date, time, and nurse checking initials.</p> <p>Towel racks will be monitored by House-keeping Supervisor during weekly environmental inspections.</p> <p>Monitored by Charge Nurse.</p> <p>Each shift monitors 50% of alarm, and each subsequent shift monitors 50% of those not inspected by the preceding shift each day.</p>	Completed 6/18/13
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F 323	<p>Continued From page 20</p> <p>06/12/13, revealed an alarm check for Resident #2, first shift occurred at 10:10 AM and revealed no other checks prior to 06/13/13 9:10 AM had been conducted.</p> <p>Interview, on 06/13/13 at 9:12 AM, Certified Nursing Assistant #1 (CNA) reveled the resident was to have bed and chair alarms.</p> <p>Observation, on 06/13/13 at 9:15 AM, Resident #2 was sitting in her wheel chair with alarm attached to the chair.</p> <p>Observation, on 06/13/13 at 9:17 AM, revealed CNA #2 checked bedside and wheelchair alarms and she detached the alarm from the wheelchair and discovered there was no batteries in the wheelchair alarm.</p> <p>Interview, on 06/13/13 at 9:17 AM, CNA #2 revealed the alarms were not plugged into the bed or to the wheelchair and the alarm on the wheelchair needed batteries.</p> <p>Interview, on 06/14/13 at 9:10 AM, Licensed Practical Nurse (LPN) #3 revealed a percentage of resident alarms were checked each shift and recorded. The residents alarms tracked each shift were recorded and turned into the Director of Nursing (DON).</p> <p>Interview, on 06/14/13 at 1:30 PM, with CNA #1 revealed she did not know the batteries were missing on 06/13/13.</p> <p>Interview by phone, on 06/14/13 at 2:10 PM, CNA #2 revealed she usually worked on A wing and reported she did not find any batteries in the</p>	F 323	

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F 323 Continued From page 21

alarm when she took the alarm back to the nurses' station and unscrewed the back and replaced the batteries. She further revealed she did not know who took the batteries out.

Interview, on 06/14/13 at 2:25 PM Registered Nurse (RN) #1 revealed that the alarm not having batteries was a safety issue and did not know how the batteries would not be in the alarm unless someone could be distracted and the alarm got put back without the batteries.

Interview, on 06/14/13 at 2:30 PM, DON revealed she received the resident alarm tracking form for each shift. The DON revealed it was a safety issue and the documented resident alarm tracking form needed to include staff testing the residents' alarms. The DON further revealed it was a safety issue for Resident #2.

2. Review of Unsampled Resident A's medical record revealed the resident was admitted by the facility on 08/10/12 with diagnoses which included Hypertension, Osteoporosis, Osteoarthritis - Unspecified, and Alzheimer's Disease. The Quarterly Minimum Data Set (MDS) Assessment, dated 05/20/13, revealed the resident was assessed to be cognitively moderately impaired.

Continued review of the quarterly MDS revealed the resident was assessed as needing extensive assistance of two (2) staff with transfers and toilet use. The MDS also indicated the resident was unsteady moving from a seated to standing position and when transferred from one surface to another.

Review of Unsampled Resident A's

F 323

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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 323	<p>Continued From page 22</p> <p>Comprehensive Care Plan for being at risk for falls, last review 05/22/13, revealed the resident was care planned for falls related to unsteady balance during transition, required staff assistance with bed mobility, transfers, and toilet usage.</p> <p>Review of the Aide Care Plan for Unsampled Resident A revealed the resident was to be assisted to the toilet.</p> <p>Observation of the bathroom in room 47 (Unsampled Resident A's room), on 06/11/13 at 2:40 PM, with Maintenance Director revealed the bathroom had no towel rack in place and towels were observed to cover the grab bar opposite the toilet.</p> <p>Interview, on 06/11/13 at 2:40 PM, with the Maintenance Director revealed the bathroom in room 47 had no towel rack and that he was unaware the towel rack had come off. He further stated the grab bar was covered with towels and was a fall risk because the resident would be unable to grab the bar, if needed to prevent a fall, because their hands would slid off with the towel.</p> <p>Interview, on 06/11/13 at 3:05 PM, with Certified Nursing Assistant (CNA) #4 revealed the towels on the grab bar could be a safety risk because a resident could not hold onto the grab bar securely if needed. The CAN stated there used to be a towel rack in the bathroom, but it had been down for awhile.</p> <p>Interview, on 06/11/13 at 3:10 PM, with Licensed Practical Nurse (LPN) #1 revealed the towels should not have been on the grab bar because</p>	F 323		

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F 323	<p>Continued From page 23</p> <p>the resident would have nothing to grip onto if they had lost their balance. She stated it would be a fall risk for the resident, who used his/her walker and required staff assistance to ambulate into the bathroom to use the toilet. She further stated the resident did not routinely use the grab bar, but if needed he/she had needed to use the towels were a hazard. The LPN stated she did not know why there was no towel rack in the bathroom and the aides should have reported this to the nurse so maintenance could have been notified.</p> <p>Interview, on 06/14/13 at 1:30 PM, with the Director of Nursing (DON) revealed they were aware the towel rack was down in room 47 and it had been put on the maintenance log to fix. She provided a copy of the Room Inspection Checklist, dated 05/28/13 which noted towel rack needed repair. She further stated the resident in room 47 was unsteady and required assistance to the bathroom. The DON further stated she was unaware towels were placed on the grab bar and it was a safety risk to use the grab bar with towels on it because you could not grip the bar properly.</p>	F 323		

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K 000 INITIAL COMMENTS

K 000

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 06/15/77

SURVEY UNDER: NFPA 101 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: One (1) story Type V (111)

SMOKE COMPARTMENTS: Six (6) smoke compartments

FIRE ALARM: Complete fire alarm system with smoke and heat detectors

SPRINKLER SYSTEM: Complete (wet) sprinkler system

GENERATOR: One (1) Type II natural gas generator.

A standard Life Safety Code survey was conducted on 06/11/13. Dover Manor was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for eighty-five (85) beds with a census of eighty-five (85) on the day of the survey.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)

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BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michael J. Felder</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/7/13</i>
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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 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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K 000	Continued From page 1 Deficiencies were cited with the highest deficiency identified at "E" level.	K 000	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, forty (40) residents, staff and visitors. The facility is licensed for eighty-five (85) beds and the census was eighty-two (82) on the day of the survey. The findings include: Observation, on 06/11/13 between 10:00 AM and 12:30 PM, revealed smoke barriers at Chapel, beside room #24 and at Lobby had penetrations not sealed around conduit piping and data wires penetrated the walls.	K 025	

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K 025 Continued From page 2

Interview, on 06/11/13 at 12:30 PM, with the Maintenance Director revealed he was unaware of the amount of penetrations observed during the survey.

Interview, on 06/11/13 at 1:15 PM, with the Administrator revealed the facility contracted with a local company to correct all smoke barriers last year and would make contact with them again to bring the smoke barriers in compliance.

Reference: NFPA 101 (2000 edition)
8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows:

- (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions:
 - a. It shall be filled with a material that is capable of limiting the transfer of smoke.
 - b. It shall be protected by an approved device that is designed for the specific purpose.
- (2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions:
 - a. It shall be filled with a material that is capable

K 025

K 025 Smoke barriers were repaired with drywall tape and mud in all areas found to have penetrations. Repairs were conducted by maintenance staff on 6/17 and 6/18, 2013.

The remaining smoke barriers in the facility were inspected on 6/18/2013, by maintenance staff.

Smoke barriers will be re-inspected by maintenance staff quarterly and will report results of inspections to CQI Committee.

K 025

Completed 6/18/2013

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K 073	Continued From page 4 documentation of flame retardant being applied. Interview, on 06/11/13 at 12:30 PM, with the Maintenance Director revealed he was aware decorations were required to be treated with a fire retardant spray but the facility did not allow the flammable decorations in the facility. He also stated that family repeatedly brought them in and the facility took them down. Interview, on 6/11/13 at 1:00 PM, with the Administrator revealed this was an ongoing problem that the facility kept taking the decorations down and family members kept bringing them back. Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	
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, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, one (1) resident, staff and visitors. The facility is	K 147	

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K 147 Continued From page 5
certified for eighty-five (85) beds and the census was eighty-two (82) on the day of the survey. The facility failed to ensure power strips and extension cords were being used properly.

The findings include:

Observations, on 06/11/13 between 10:00 AM and 12:30 PM, with the Maintenance Director, revealed a hair dryer and three (3) curling irons plugged into a power strip that was also plugged into another power strip in the beauty shop. The appliances were not being used at the time of survey nor were any residents present.

Interview, on 06/11/13 at 12:30 PM, with the Maintenance Director, revealed he was unaware of the power strips being used in the beauty shop.

Interview on 06/11/13 at 1:00 PM, with the Administrator revealed that the power strips would be taken care of.

Reference: NFPA 99 (1999 edition)
3-3.2.1.2 D

Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.

K 147

K 147 The power strip was removed from the beauty parlor cart on 6/14/2013.

Two additional wall receptacles were added to the beauty shop on 6/14/2013/

The Beautician was instructed in the use of electrical power strips on 6/15/2013 and is now using the new wall receptacles.

The power strip has not been returned to the beauty shop.

K 147

Completed 6/17/2013