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

PRINTED: 06/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185295	A. BUILDING _____ B. WING _____	05/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOVER MANOR	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 000	INITIAL COMMENTS	F 000		
	A Recertification Survey was initiated on 05/16/12 and concluded on 05/18/12. Deficiencies were cited with the highest scope and severity of an "F".		RECEIVED JUN - 7 2012	
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY	F 372		
	The facility must dispose of garbage and refuse properly.	F 372	The defective dumpster lid was replaced on 5/17/12, by Veolia. A copy of their call log and work order is attached.	
	This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store garbage and refuse properly to prevent the harborage of insects, rodents, or other wildlife. The facility failed to ensure one (1) of two (2) dumpster containers were fully covered.		The Dietary Manager has created a log for daily inspection of the dumpsters. The dumpsters will be inspected on a daily basis and initialed by the Dietary Manager/Cook completing the inspection. Damage to lids or dumpsters will immediately be reported to the Maintenance Director.	
	The findings include:		Results of inspections and any needed repairs shall be reported to the CQI Committee on a weekly basis.	
	Observation during the Environmental Tour, on 05/16/12 at 1:15 PM, revealed the lid of one (1) of the dumpsters was only half present. Observation on 05/17/12, at 1:17 PM, revealed the dumpster lid was still missing.		Compliance shall be monitored by the CQI Committee.	
	Interview with Dietary Aide #9, on 05/18/12 at 5:50 PM, revealed the kitchen staff took the trash from the kitchen to the dumpsters outside surrounded by the white fence. Further interview revealed both dumpsters were used by the kitchen and they should have lids to keep insects and other pests away.	F 372	Completed 5/19/12	
	Interview with Maintenance Director, on 05/17/12			

per TO call c̄ M. Belden 6/27/12

5/19/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Belden	Administrator	6/7/12

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 372	Continued From page 1 at 1:17 PM, revealed the dumpster was the responsibility of the kitchen staff and that he was unaware the lid was missing. Interview with the Director of Nursing (DON), on 05/18/12, at 4:15 PM, revealed the dumpster with the missing lid was an infection control issue. Further interview revealed the dumpster should have a full lid on it at all times.	F 372		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview, record review and a review of the facility's policy, it was determined the facility failed to ensure Physician's admission orders were signed and dated. Review of the medical records revealed the facility failed to ensure two (2) of seventeen (17) sampled residents (Residents #15's and #16's) admission orders were signed and dated by the Physician. The findings include:	F 386 F 386	Physician's Orders for resident #15 and #16 have been signed by their respective Physicians. All Physician Orders in the facility have been reviewed by the DON, Jamie Pierce, LPN, and Nikki Jones, Medical Records on 5/21, 5/22, and 5/23/12. All additional unsigned Physician Orders have been signed. MDS Coordinators will monitor Physician's Orders upon admission and subsequent to admission for completion. Unsigned orders will be immediately identified and brought to the attention of Medical Records who will insure the order is signed. Compliance will be monitored by the CQI Committee on a weekly basis. **Completed 5/24//12**	

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F 386	Continued From page 2 Review of the facility's policy entitled, "Physician Orders" (no date), revealed Physician's admission orders for the resident's immediate care were obtained from the attending Physician on admission and should be signed and dated by the Physician. 1. Review of the medical record for Resident #15 revealed the facility admitted Resident #15 on 02/01/12 with diagnoses which included Cerebral Vascular Accident, history of two back surgeries, Diabetes Type 2, Hypertension, questionable Hepatitis C from transfusion, Appendectomy, Bradycardia and Anxiety. Review of the admission orders revealed no documented evidence the orders were dated or signed by the admitting Physician. 2. Review of the medical record for Resident #16 revealed the facility admitted Resident #16 on 01/10/12 with diagnoses which included a non-healing ulcer and Cellulitis of the right lower extremity, Peripheral Vascular Disease, history of Deep Vein Thrombus, history of Iron Deficiency, Anemia, Diabetic Type 2, Hypertension, Gastroesophageal Reflux Disease, History of Polymyalgia, Rheumatic Weakness, Depression and Aortic Aneurysm. Review of the admission orders revealed no documented evidence the orders were dated or signed by the admitting Physician. Interview, on 05/18/12 at 6:00 PM, with the Director of Nursing (DON) revealed the admission orders should have been signed and dated by the admitting Physician.	F 386		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 3 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 prevent the spread of infection, the facility must isolate the resident. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 4	F 441		
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to 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. Observation during meal service, on 05/16/12 at 8:20 AM, revealed staffs' hands were coming into direct contact with the residents' food. The findings include: Review of the facility's policy entitled, "Feeding the Resident (Dependent Eating)" (no date), revealed under section "General Infection Control Guidelines", staff should wash hands before and after all procedures, and should wear gloves when appropriate. Interview, on 05/18/12 at 3:35 PM, with Licensed Practical Nurse (LPN) #1, revealed she thought the facility's process for applying butter or jam to a resident's toast was not to touch the toast. She stated staff should leave it on the plate or use a glove. She stated this was to ensure organisms on the hands did not get transferred to the bread. Observation of the breakfast meal, on 05/16/12 at 8:27 AM, revealed State Registered Nurse Aide (SRNA) #2's hands, not wearing gloves, came into direct contact with Unsampled Resident A's food, while applying butter and jam to the resident's toast.	F441	In-services have been held with all Dietary staff and Nursing staff on 5/22, 5/23, and 6/5/12, which were conducted by the Dietary Manager, and on 6/6/12, which was conducted by the RD, covering bare hand contact with food, dumpster lid and surrounding area housekeeping, food service requirements, and reading of tray cards. Bread is delivered in a wax paper bag and an additional piece of waxed paper is now available on the food service carts to assist those employees who feel it is helpful for placing condiments on the bread without making contact. The DON and Charge Nurses have monitored meal service and have continued to instruct as necessary. Compliance will be monitored by the CQI Committee in weekly meetings. **Completed 6/7/12**	
		F 441		

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F 441	Continued From page 5 Observation of the breakfast meal, on 05/16/12 at 8:29 AM, revealed SRNA #4's hands, not wearing gloves, came in direct contact with Unsampled Resident B's food, while applying butter and jam to a resident's toast. Observation of the breakfast meal, on 05/16/12 at 8:34 AM, revealed SRNA #5's hands, not wearing gloves, came in direct contact with Unsampled Resident C's food, while applying butter and/or jam to a resident's toast. Interview, on 5/18/12 at 2:40 PM, with SRNA #2 revealed she thought the facility's process for applying butter or jam to a resident's toast would be to wash hands/sanitize hands, use the plastic wrapper as a barrier while buttering the bread so as to not touch the bread. Interview further revealed when asked if SRNA #2 used this process at all times, SRNA #2 said "oh well I guess not all of the time". Continued interview revealed she should not have touched the food with her hands due to contamination and bacteria.	F 441		

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	185295	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/16/2012

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K 000	INITIAL COMMENTS 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: Four (4) 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 05/16/12. 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)	K 000		

RECEIVED
JUN - 7 2012
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Fuldam	Administrator	6/7/12

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K 000	Continued From page 1	K 000		
	Deficiencies were cited with the highest deficiency identified at "D" level.			
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		
	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	The sprinkler head located in the employee break room was re-positioned by Simples-Grinnell on 5/23/12. The sprinkler head is now in compliance with requirements. The Maintenance Director and Administrator inspected the entire facility on 5/21/12, and were unable to identify any additional sprinkler heads which did not meet requirements. The Maintenance Director will continue to supervise any future improvements to ensure continued compliance.	
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained, according to National Fire Prevention Association (NFPA) standards. The findings include: Observation, on 06/16/12 at 1:12 PM, revealed a sprinkler head located in the mechanical closet in the employee break room was located too close to the wall, less than four (4) inches. The observation was confirmed with the Maintenance Director. Interview, on 05/16/12 at 1:12 PM, with the Maintenance Director, revealed he was unaware of these requirements. Reference: NFPA 13 (1999 edition) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.	K 062	**Completed 5/24/12**	