

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
--	---	--	---

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 000}	INITIAL COMMENTS An On-site Revisit Survey was conducted 06/24/14 through 06/26/14, to determine if the facility was in substantial compliance on 06/18/14, as alleged per their acceptable Plan of Correction (POC) for the 05/08/14 Recertification Survey. The findings of the revisit determined the facility failed to ensure the POC was implemented and the following deficiencies were not corrected on 06/18/14 as alleged: 42 CFR 483.10 Resident Rights (F166), 42 CFR 483.13 Resident Behavior and Facility Practices (F225 & F226), 42 CFR 483.20 Resident Assessments (F282), and 42 CFR 483.25 Quality of Care (F323). Two new deficiencies were cited at 42 CFR 483.75 Administration (F490 and F520) with the highest Scope and Severity of a "D".	{F 000}		
{F 166}	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES SS=D A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's Plan of Correction (POC) it was determined the facility failed to implement the POC which was developed to address the findings of the Recertification Survey conducted 05/06/14 through 05/08/14. The Recertification Survey determined the facility failed to resolve Unsampld Resident A's grievance promptly, failed to seek a resolution, and failed to keep the resident informed of the follow-up regarding	{F 166}		

RECEIVED
JUL 17 2014
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Michael J. ... Administrator* TITLE: *Administrator* (X6) DATE: *7/17/14*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
--	--	--	---

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 166} Continued From page 1
his/her report of missing money.

Review of the facility's Plan of Correction (POC) revealed: all residents in the facility with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater were to be interviewed pertaining to any issues, financial or otherwise, that might have been unresolved; a new Grievance Form was to be created to report issues to the Social Services Director (SSD); and, all staff was to be inserviced on the new form and procedures by the SSD and Director of Nursing (DON) by 05/30/14. However, interview and record review revealed the facility failed to implement the POC.

The findings include:

Review of the facility's POC, dated and signed by the Administrator on 06/13/14 with a compliance date of 05/31/14, revealed Unsampled Resident A was interviewed by the SSD regarding his/her general feelings of well-being in regards to the facility. Review of the POC revealed all residents in the facility with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater were to be interviewed pertaining to any issues, financial or otherwise, that might have been unresolved. Continued review of the POC revealed a new Grievance Form was to be created to report issues to the Social Services Director, and all staff was to be inserviced on the new form and procedures by the SSD on 05/13/14, 05/19/14 and 05/28/14 through 05/30/14. Additionally, the Director of Nursing (DON) was to have assisted with the staff inservices on the new form and procedures on 05/14/14 and 05/27/14.

Interview with the SSD, on 06/25/14 at 1:33 PM,

{F 166} All residents with a BIMS score of 8 or higher were interviewed by the SSD between 6/26 and 7/7/14. No residents voiced any concerns regarding complaints, treatment of staff, missing items, quality of care, staff resolution of grievances or issues of any kind. No grievances were voiced that were current or in the past.

The Administrator is in possession of the list of residents and the questions asked by the SSD during the time period in question.

A new Grievance form was created on 6/26, by the SSD and copies of the form were placed in the main office and at both nursing stations. The Administrator is in possession of a copy of the Grievance form.

All employees in the facility were in-serviced between 6/26-7/7/14, on Abuse and Grievance procedures, including where the forms are housed, how to prepare the form, and how to contact the SSD. Even those employees in-serviced previously were in-serviced a second time.

The Administrator has reviewed all of the sign-in sheets pertaining to the in-services and has verified that all employees have received the in-services required. A copy of the sign-in sheets, materials covered in the in-services, and the employee roster are in the possession of the Administrator.

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
--	---	--	---

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 166} Continued From page 2
revealed there were no further encounters regarding Unsampld Resident A's missing property after she had notified the daughter. She continued by stating that a complete and thorough investigation should have been conducted. The SSD revealed she had not interviewed Unsampld Resident A as to his/her general feelings of well-being regarding the facility as alleged in the POC. Continued interview revealed she had also not conducted interviews with other residents as alleged in the POC. The SSD stated she must have been confused as to what she should have interviewed on and when she was supposed to do the interviews. She stated she had not developed a "new" Grievance Form, and indicated her only involvement was to add Management staff who should receive a copy of the completed Grievance Form to the lower left hand corner of the previous/current form. According to the SSD, she took the revised Grievance Form when she inserviced staff in May. She indicated she had not been educated on the POC process by the DON or Administrator.

Interview with the Director of Nursing (DON), on 06/25/14 3:18 PM, revealed the "new" Grievance Form was developed either 05/08/14 or 05/09/14, right after the survey. The DON stated she took the new form with her to share during the staff inservices she completed on 05/14/14 and 05/27/14.

However, interviews with staff revealed they had not received education related to the "new" Grievance Form. Interview with Licensed Practical Nurse (LPN) #8, on 06/25/14 at 2:40 PM and 06/26/14 at 9:43 AM, and with LPN #13, on 06/25/14 at 3:56 PM, revealed they had no

{F 166}
F 166 A new position has been created: that of Staff Coordinator. The Staff Coordinator is now responsible for ensuring that staff in-services are completed by all staff and has created a log on 7/14/14, that will keep a running list of all employees and the status of their in-services.

A new Quality Assurance Professional Improvement program has been adopted from the CMS.gov website and has been put into place in the QA Committee, creating a completely new means of establishing compliance of all issues within the facility utilizing Action Plans, assignment, required completion dates, thereby ensuring accountability.

Compliance will be monitored by the Staff Coordinator and the QA Committee.

F 166 **Completed 7/15/14**

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

 PRINTED: 07/11/2014
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/26/2014
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 166}	<p>Continued From page 3</p> <p>knowledge of any new Grievance Form and had not been inserviced on a new Grievance Form.</p> <p>Interview with LPN #9, on 06/26/14 at 10:00 AM, revealed to her knowledge there was not a new Grievance Form, nor had she been educated on a new Grievance Form since the May 2014 survey. LPN #9 stated the SSD had come to her that morning, 06/26/14, to verify she knew the forms were kept at both nurse's stations.</p> <p>Interviews with LPN #6, on 06/26/14 at 10:29 AM, LPN #3 at 10:49 AM, and LPN #12 at 11:14 AM, revealed they were unsure if the Grievance Forms were new or not and did not remember being educated on any new forms after the May 2014 survey. LPN #3 stated she had not received education on the Grievance Form until that morning, 06/26/14, when the SSD "came around" to educate her on the use of the form and the location of it.</p> <p>Interview with Registered Nurse (RN) #3, on 06/26/14 at 12:22 PM, revealed she had worked since 05/13/14; however, had only received the inservice on the Grievance Form "yesterday", 06/25/14.</p> <p>Interview with the Administrator, on 06/25/14 at 3:28 PM and 5:45 PM, revealed it was his expectation that the SSD had understood that he had wanted her to interview all residents in the facility with a BIMS of eight (8) or greater about any issue, financial or otherwise, that had been resolved and their general feelings of well-being about the facility. The Administrator stated it had been his expectation for the SSD to conduct the resident interviews indicated in the POC as soon as possible. He continued by stating it was clear</p>	{F 166}		

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
--	---	--	---

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 166}	Continued From page 4 to him who should have conducted the interviews and also that all staff was to be inserviced.	{F 166}		
{F 225} SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	{F 225}	<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 certification agency) within 5 working days of the incident, and if the alleged violation is verified</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
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 225} Continued From page 5
appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:

Based on interview, record review, and review of the facility's Plan of Correction (POC) it was determined the facility failed to implement the POC which was developed to address the findings of the Recertification Survey conducted 05/06/14 through 05/08/14. The Recertification Survey determined the facility failed to have an effective system in place to ensure injuries of unknown origin were immediately reported to the Administrator and appropriate State Agencies.

Review of the facility's Plan of Correction (POC) revealed the Social Services Director (SSD) was to interview all residents in the facility with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater and all staff were to be inserviced on the all aspects of Abuse, to include injuries of unknown origin by the SSD and Director of Nursing (DON) by 05/30/14. Continued review of the POC revealed "all existing employees" had been inserviced. However, interview and record review revealed the facility failed to implement the POC.

The findings include:

Review of the facility's POC, dated and signed by the Administrator on 06/13/14, and with an alleged compliance date of 06/10/14, revealed the Social Services Director (SSD) was to interview all residents with a Brief Interview for Mental Status (BIMS) score of eight (8) or above. The POC revealed the SSD was to have

{F 225}

F 225 All residents with a BIMS score of 8 or higher were interviewed by the SSD between 6/26 and 7/7/14. No residents voiced any concerns regarding complaints, treatment of staff, missing items, quality of care, staff resolution of grievances or issues of any kind. No resident indicated they had any grievance current or in the past that was unresolved.

The Administrator is in possession of the list of residents and the questions asked by the SSD during the time period in question.

All employees were in-serviced between 6/26-7/7/14, on Abuse and Grievance procedures, including injuries of unknown origin by the SSD and the DON. Even those employees in-serviced previously were in-serviced a second time.

The Administrator has reviewed all of the sign-in sheets pertaining to the in-services and has verified that all employees have received the in-services required. A copy of the sign-in sheets, materials covered in the in-services, and the employee roster are in the possession of the Administrator.

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
--	--	--	---

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 225} Continued From page 6

conducted inservice education for all staff on all aspects of abuse, to include injuries of unknown origin. The inservice education was to have been conducted on 05/13/14, 05/19/14 and 05/28/14 through 05/30/14. Per the POC, the DON assisted with conducting the abuse inservice education on the same topics on 05/14/14 and 05/19/14 for all staff.

Interview with the SSD, on 06/25/14 at 1:33 PM, revealed she had not conducted interviews with all residents in the facility with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater as indicated by the POC to determine no other residents were impacted by the deficient practice. Continued interview with the SSD revealed she must have misunderstood what she was supposed to do. The SSD indicated the DON or Administrator had not educated her on the POC process. Interview further revealed the SSD had conducted the inservice education for staff on 05/13/14, 05/19/14, 05/28/14, 05/29/14 and 05/30/14 as per the POC.

However, review of the facility's Abuse education inservice sign-in sheets compared to the facility's master employee list revealed twenty-four (24) of one hundred and forty-five (145) employees were not inserviced and had been allowed to work without the Abuse in-services.

Interview with the DON, on 06/26/14 at 12:40 PM, revealed she had not monitored to ensure all staff had received the inservices. The DON revealed staff she knew could not make it in were inserviced when "they came in on their shift". She stated she "thought" all staff had attended the inservices; however, indicated she should have had a system in place to assure all staff had

{F 225}

F 225 A new position has been created: that of Staff Coordinator. The Staff Coordinator is now responsible for ensuring that staff in-services are completed by all staff and has created a log on 7/14/14, that will keep a running list of all employees and the status of their in-services.

A new Quality Assurance Professional Improvement program has been adopted from the CMS.gov website and has been put into place, creating a completely new means of establishing compliance of all issues within the facility utilizing Action Plans, assignment, and required completion dates.

Compliance will be monitored by the Staff Coordinator and the QA committee.

F 225 Completed 7/15/14

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
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)

{F 225} Continued From page 7
been inserviced.

Interview with State Registered Nursing Assistant (SRNA) #17 on 06/26/14 at 11:28 AM revealed she indicated she had not received abuse training since May 2014.

Interview with Medical Records Clerk #1 on 06/26/14 at 11:37 AM, revealed she had not attended abuse inservice since the survey in May 2014. She further stated she had not been advised by the Administrator or the (DON) that she needed to attend the Abuse inservice.

Interview with Registered Nurse (RN) #4 on 06/26/14 at 11:14 AM, with SRNA #20 at 11:50 AM, with RN #3 at 12:22 PM, with LPN #5 on 06/26/14 at 1:05 PM, with LPN #14 at 1:10 PM, with SRNA #18 at 2:05 PM, with SRNA #16 at 2:15 PM, with Activity/Clerical Staff #1 on 06/26/14 at 3:15 PM and with Laundry Staff #1 on 06/26/14 at 3:35 PM revealed they had not received abuse inservice training after the survey in May 2014.

Interview with the Administrator, on 06/25/14 at 5:45 PM, revealed the facility's abuse policies had been used as an education tool to educate the SSD on the abuse protocol. He revealed it had been his understanding that staff involved with the POC were aware of what their assignments were regarding the POC.

{F 226} 483.13(c) DEVELOP/IMPLMENT
SS=D ABUSE/NEGLECT, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents

{F 225}

{F 226}

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
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)

{F 226} Continued From page 8 and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:

Based on interview, record review, and review of the facility's Plan of Correction (POC) it was determined the facility failed to implement the POC which was developed to address the findings of the Recertification Survey conducted 05/06/14 through 05/08/14. The Recertification Survey determined the facility failed to have an effective system in place to ensure policies and procedures were implemented related to reporting injuries of unknown origin.

Review of the facility's Plan of Correction (POC) revealed the Social Services Director (SSD) and the Director of Nursing (DON) were to have conducted inservice education with all existing employees on all aspects of the facility's abuse policies and procedures by 05/30/14. Continued review of the POC revealed staff not in compliance with the inservice training requirements would not be allowed to work until they had received the inservices. However, record review and interview revealed the facility failed to implement the POC.

The findings include:

Review of the facility's POC, dated and signed by the Administrator on 06/13/14, and with an alleged compliance date of 06/10/14, revealed the Social Services Director (SSD) was to have conducted inservice education for all staff on all aspects of all aspects of the facility's abuse policies and procedures, to include injuries of

{F 226}

F 226 All employees were in-serviced between 6/26-7/7/14, on Abuse and Grievance procedures, including injuries of unknown origin by the SSD and the DON. Even those employees in-serviced previously were in-serviced a second time.

The Administrator has reviewed all of the sign-in sheets pertaining to the in-services and has verified that all employees have received the in-services required. A copy of the sign-in sheets, materials covered in the in-services, and the employee roster are in the possession of the Administrator.

A new position has been created: that of Staff Coordinator. The Staff Coordinator is now responsible for ensuring that staff in-services are completed by all staff and has created a log on 7/14/14, that will keep a running list of all employees and the status of their in-services.

A new Quality Assurance Professional Improvement program has been adopted from the CMS.gov website and has been put into place, creating a completely new means of establishing compliance of all issues within the facility utilizing Action Plans, assignment, and required completion dates.

Compliance will be monitored by the Staff Coordinator and the QA Committee.

F 226

Completed 7/15/14

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
--	--	--	---

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 226} Continued From page 9

unknown origin and timeliness and accuracy of reporting. The inservice education was to have been conducted on 05/13/14, 05/19/14 and 05/28/14 through 05/30/14. Continued review of the POC revealed on 05/14/14 and 05/19/14, the DON assisted with conducting the inservice education on the facility's abuse policies and procedures. The POC revealed staff not in compliance with the training requirements would not be allowed to work until they had received the inservice education.

However, review of the facility's Abuse education in-service sign-in sheets compared to the facility's master employee list revealed twenty-four (24) of one hundred and forty-five (145) employees were not in-serviced as indicated in the POC, and had been allowed to work without the inservice education on the facility's abuse policies and procedures.

Interview, on 06/26/14 at 11:14 AM with Registered Nurse (RN) #4, on 06/26/14 at 11:14 AM, with Medical Records Clerk #1 at 11:37 AM, with SRNA #20 at 11:50 AM, with RN #3 at 12:22 PM, with LPN #5 on 06/26/14 at 1:05 PM, with LPN #14 at 1:10 PM, with SRNA #18 at 2:05 PM, with SRNA #16 at 2:15 PM, with Activity/Clerical Staff #1 on 06/26/14 at 3:15 PM and with Laundry Staff #1 on 06/26/14 at 3:35 PM revealed they had not been educated in May 2014 on the facility's abuse policies and procedures, as indicated in the POC which stated all existing employees were to have received the education by 05/30/14.

Interview, on 06/25/14 at 2:25 PM and 5:45 PM, with the Administrator revealed he had depended on staff to ensure the POC was carried out and

{F 226}

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
--	---	---	---

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 226} Continued From page 10
did not verify the education was completed per the POC.

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

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

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of the facility's Plan of Correction (POC) it was determined the facility failed to implement the POC which was developed to address the findings of the Recertification Survey conducted 05/06/14 through 05/08/14. The Recertification Survey determined the facility failed to ensure interventions on the Comprehensive Care Plan were implemented related to transferring a resident with a Hoyer lift. Staff was utilizing a "towel" method, instead of the Hoyer lift, which resulted in a resident fall with injury.

Review of the facility's Plan of Correction (POC) revealed inservice education was provided to all staff regarding transfers and following the Comprehensive Care Plan. However, interview and record review revealed the facility failed to implement the POC.

The findings include:
Review of the facility's POC, dated and signed by the Administrator on 06/13/14, with an alleged compliance date of 06/13/14, revealed inservice

{F 226}

F 282

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/26/2014
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 282	Continued From page 11 education was conducted by the Director of Nurse (DON) and Physical Therapy (PT) on 05/19/14, 05/20/14 and 05/22/14 regarding utilizing the lifting technique indicated on the Comprehensive Care Plan. The POC revealed the DON educated Minimum Data Set (MDS) Nurses regarding changes in the procedure for care plans on 05/28/14. Continued review of the POC revealed the DON provided inservice education to all Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Kentucky Medication Aides (KMAs), and State Registered Nursing Assistants (SRNAs) regarding following the Comprehensive Care Plan on 06/09/14, 06/10/14, 06/11/14, and 06/12/14. The POC stated "all nursing staff attended the training". However, review of the facility's care plan inservice attendance record compared to the facility's master employee list revealed twenty-four (24) of one hundred and five (105) nursing employee's had not received the education on following the care plan. Interview on 06/26/14 with SRNA #18 at 11:15 AM, with SRNA #17 at 11:26 AM, with SRNA #20 at 11:50 AM, SRNA #21 at 2:35 PM, with SRNA/KMA #19 at 12:31 PM, with LPN #5 at 1:05 PM, and with LPN #7 at 3:30 PM, revealed they had not received the care plan inservice education provided by the DON as per the POC. Interview with the DON on 06/25/14 at 3:00 PM and on 06/26/14 at 12:40 PM, revealed she "thought" all the nursing staff had attended the care plan inservice education. The DON indicated she did not have a system in place to track and ensure all nursing staff received the care plan inservice education per the POC, but	F 282	All nursing staff was in-serviced by the DON and Physical Therapy, Leslie Shipley, between 5/14-7/7/14 in the facility Lift and Transfer Policy. The Administrator has verified the sign-in sheets against the employee roster and has a copy of these materials, as well as the policy in his possession. A new position has been created: that of Staff Coordinator. The Staff Coordinator is now responsible for ensuring that staff in-services are completed by all staff and has created a log on 7/14/14, that will keep a running list of all employees and the status of their in-services. A new Quality Assurance Professional Improvement program has been adopted from the CMS.gov website and has been put into place, creating a completely new means of establishing compliance of all issues within the facility utilizing Action Plans, assignment of tasks, and required completion dates. Compliance will be monitored by the Staff Coordinator and QA Committee.		
		F 282	Completed 7/15/14		

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
--	--	--	---

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 282	<p>Continued From page 12 should have had a system.</p> <p>Interview with the Administrator on 06/25/14 at 1:00 PM and on 06/26/14 at 2:25 PM, revealed he had taken "the word" of the employees assigned to ensure the education was provided as per the POC; however, should have "done more checking" and not just relied on the employees' word. He stated the facility should have had a system in place to assure education was completed and to monitor for any issues.</p> <p>{F 323} 483.25(h) FREE OF ACCIDENT SS=D 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> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's Plan of Correction (POC) it was determined the facility failed to implement the POC which was developed to address the findings of the Recertification Survey conducted 05/06/14 through 05/08/14. The Recertification Survey determined the facility failed to ensure required devices were utilized during a transfer which resulted in a resident fall with injury.</p> <p>Review of the facility's Plan of Correction (POC) revealed all State Registered Nursing Assistants (SRNAs), Kentucky Medication Aides (KMAs) and</p>	F 282		
-------	---	-------	--	--

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
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)

{F 323} Continued From page 13
all nurses were to have been inserviced by the Director of Nursing (DON) on safe lifting techniques and the use of equipment during transfers. However, record review and interview revealed the facility failed to implement the POC.

The findings include:

Review of the facility's POC, dated and signed by the Administrator on 06/13/14, with an alleged compliance date of 05/31/14, revealed all State Registered Nursing Assistants (SRNAs), Kentucky Medication Aides (KMAs) and all nurses were inserviced by the Director of Nursing (DON) on 05/14/14 and 05/27/14, on safe lifting techniques and equipment during transfers.

However, review of the facility's master employee list in comparison to the inservice attendance records revealed twenty-one (21) of one hundred and five (105) nursing employees had not received the education on use of equipment and safe lifting techniques during transfers, to have been provided by the DON per the POC.

Interview with SRNA #20, on 06/26/14 at 10:55 AM, revealed she had not received the inservice education on transfers as she worked night shift and was not at the facility when the education was provided.

Interview with SRNA #17, on 06/26/14 at 11:26 AM, revealed she had not received the inservice education on transfers until the morning of 06/26/14. She further stated she had worked and had transferred residents with the "sling" lift.

Interview with SRNA #22, on 06/26/14 at 11:30 AM revealed she had not received any inservice

{F 323}
N 323 All nursing staff was in-serviced by the DON and Physical Therapy, Leslie Shipley, between 5/14-7/7/14 in the facility Lift and Transfer Policy.

The Administrator has verified the sign-in sheets against the employee roster and has a copy of these materials, as well as the policy in his possession.

A new position has been created: that of Staff Coordinator. The Staff Coordinator is now responsible for ensuring that staff in-services are completed by all staff and has created a log on 7/14/14, that will keep a running list of all employees and the status of their in-services.

A new Quality Assurance Professional Improvement program has been adopted from the CMS.gov website and has been put into place, creating a completely new means of establishing compliance of all issues within the facility utilizing Action Plans, assignment of tasks, and required completion dates.

Compliance will be monitored by the Staff Coordinator and QA Committee.

F 323 Completed 7/15/14

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 06/26/2014
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 323}	Continued From page 14 education on transfers, as she was busy during the training and "didn't have time" to attend. SRNA #22 stated she had received training on the "transfer sling" earlier that morning. She stated she had transferred two (2) residents with the sling everyday she had worked since 06/02/14. Interview with SRNA #15, on 06/26/14 at 1:38 PM, revealed she worked as the Activity Aide and she did assist to transfer residents into chairs for activities. She further stated she had not received the inservice education on transfers; however, was scheduled to attend the inservice at 2:00 PM that day, 06/26/14. Interview with SRNA #18, on 06/26/14 at 2:06 PM, revealed she had not received the inservice education on transfers. She stated she used the "sling lift" when she worked. SRNA #18 indicated the DON had told her she would provide her the transfer education; however, she had not done so at that time. According to SRNA #18, she had never been trained by anyone but other SRNAs on the "lifts and sling lift". Interview with LPN #7, on 06/26/14 at 3:30 PM, revealed she had not attended the inservice education on transfers in May 2014. Interview with RN #4, on 06/26/14 at 11:14 AM revealed she had not received inservice education on transfers since the survey in May 2014. However, she stated she had provided inservice education on transfers to the SRNAs "the other day". Interview with the DON, on 06/26/14 at 12:40 PM and 2:25 PM, revealed she had no system in	{F 323}		

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
--	--	--	---

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 323} Continued From page 15
place to track the inservice education attendance to assure all staff received the required education per the facility's POC. According to the DON, she "thought" all the nursing staff had received the inservice education; however, she stated she had not performed monitoring of the inservice education to ensure all staff had received it.

Interview with the Administrator, on 06/26/14 at 2:25 PM, revealed he had not required documented evidence the inservice education had been completed. The Administrator revealed the "only way" he would know if a problem occurred during the DON's and nurses' observations was if there was a negative outcome which would result in re-education of staff.

F 490 483.75 EFFECTIVE
SS=D ADMINISTRATION/RESIDENT WELL-BEING

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

Based on interview, record review, and review of the facility's Plan of Correction (POC) it was determined the facility failed to implement the POC which was developed to address the findings of the Recertification Survey conducted 05/06/14 through 05/08/14. The facility failed to ensure all residents were interviewed; failed to ensure inservice education was provided to

{F 323}
F 490 The Administrator has available resources in multiple forms that were utilized to develop systems required to bring the facility into compliance and to continue to attain or maintain the highest practicable physical, mental, and psychosocial well-being of ach resident.

The Administrator has performed daily direct observation of the facility since June 26, 2014, as well as public and non-public areas.

F 490 The Administrator has provided the resources necessary to provide in-services to all employees, to restructure staff creating the new position of Staff Coordinator, developing and creating a new Quality Assurance Professional Improvement (QAPI) program, new Action Plan forms, and adopting a new QA Committee procedure, as well as a new facility maintenance log.

The Administrator has assisted in developmen and creation of forms, reviewed records for accuracy and consistency, monitored meals daily, participated in weekly QA Committee meetings, participated in stand-up meetings on a daily basis, assisted in conducting in-services, and provided progress reports to Board of Directors.

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
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)

F 490 Continued From page 16
employees as indicated; and failed to monitor as per the POC. This failure resulted in continued non-compliance at 42 CFR 483.10 Resident Rights (F166), 42 CFR 483.13 Resident Behavior and Facility Practices (F225 & F226), 42 CFR 483.20 Resident Assessments (F282), and 42 CFR 483.25 Quality of Care (F323).

The findings include:

Review of the facility's POC with an alleged compliance date of 06/18/14, revealed all residents in the facility capable of understanding the questions pertaining to any grievances were interviewed; however, interview with the Social Services Director (SSD) on 06/25/14 at 1:33 PM revealed she had not interviewed the residents. (Refer to F166)

Continued review of the facility's POC revealed all staff had been in-serviced on the grievance procedure and forms (Refer to F166), abuse with special emphasis on injury of unknown origin and reporting (Refer to F225 and F226), lift equipment (Refer to F323), and implementation of care plans (Refer to F282). However, review of the facility's master employee list compared to the inservice attendance records revealed twenty-four (24) of one hundred and forty-five (145) employees had not received inservice education per the POC and had worked in the facility since 06/18/14. Interviews with staff revealed they had not received education per the POC.

Interview with the Director of Nursing (DON), on 06/26/14 at 12:30 PM, revealed she had no system in place to track inservice education attendance to assure all staff received the

F 490 Cont.

Further, the Administrator has had direct resident observation and interaction, direct staff observation and interaction, and interaction with family members on multiple shifts on a regular basis. If immediate action were to be required before report to the QA Committee, the Administrator would take this action. The action is tasked to the role that would resolve the issue.

The Administrator will direct the efforts of the employees of the facility and directly oversee their actions in order to implement the Plan of Correction. Additional financial resources will be made available as needed to ensue the success of the implementation.

The Administrator will be available on a daily basis twenty-four hours per day as needed to answer questions, provide guidance, and authorize utilization of resources as necessary.

Furthermore, the Administrator will directly participate in the QA Committee meetings in order to monitor the performance of employees and measure their progress.

The Board of Directors have taken an active part in overseeing the operation of the facility.

F 490 Completed 7/15/14

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
--	---	--	---

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 490	<p>Continued From page 17</p> <p>required education per the facility's POC. Continued review of the facility's master employee list compared to employee time sheets revealed a new employee was allowed to work an 11:00 PM to 7:00 AM shift prior to receiving abuse training education. However, review of the facility's POC revealed new hires would receive training on abuse procedures prior to working the floor. Continued interview with the DON revealed the facility tried to complete abuse training for new hires before they worked the floor; however, this new employee could not come in during the day, and so she (the DON) had come in early the next morning to do the abuse training.</p> <p>Interview with the Administrator, on 06/26/14 at 2:25 PM, revealed staff had been assigned areas of the POC, and he had depended on the staff's "word" they had completed their assignments. He stated however, he should have checked himself to make sure the staff knew what they were to do and had correctly completed their assignments. The Administrator indicated he should have had a monitoring system in place to assure the POC was implemented.</p> <p>F 520 483.75(o)(1) QAA SS=D COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify</p>	F 490 F 520	<p>Quality assurance meetings have been held on 7/1, 7/8, and 7/14/14 to address the corrective actions necessary to implement in order to achieve compliance with Tags cited at F166, F225, F226, F282, F323, and F490.</p> <p>The structure of the Quality Assurance Committee has been altered, and a new Quality Assurance Professional Improvement (QAPI) program has been adopted and utilized to initiate action. Additional employees have been added to the committee from several levels in order to add a new perspective to resolving issues, consistent with the QAPI approach. We have also begun utilizing Action Plans that are assigned to individuals or groups, as required, to require completion dates and accountability for resolution of issues identified by the committee.</p> <p>Additional temporary individuals may be added to the Committee from time to time in order to best address the issues at hand.</p> <p>We have added a position of Staff Coordinator to the facility. That individual will be responsible for ensuring that all employees in the facility remain current with all in-service requirements.</p>	
-------	--	----------------	--	--

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
--	--	--	---

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 520 Continued From page 18

issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on interview and review of the facility's Plan of Correction (POC) with an alleged compliance date of 06/18/14, it was determined the facility failed to have an effective Quality Assessment and Assurance (QA) Program to monitor and implement the POC which was developed to address the findings of the Recertification Survey conducted 05/06/14 through 05/08/14 at 42 CFR 483.10 Resident Rights (F166), 42 CFR 483.13 Resident Behavior and Facility Practices (F225 & F226), 42 CFR 483.20 Resident Assessments (F282), and 42 CFR 483.25 Quality of Care (F323).

The findings include:

Review of the facility's POC with an alleged compliance date of 06/18/14, revealed residents in the facility with a Brief Interview for Mental Status (BIMS) score of eight (8) or greater were

F 520 Cont.

QA meetings will be held every Monday at 11:00 AM. The members of the QA committee will assemble in order to identify issues within the facility that require QAPI Action Plan assignment.

The Quality Assurance Committee will have the authority to utilize the resources of the facility to the best advantage of the needs of the facility. The QA Committee will have the ability to have direct contact with the Board of Directors of the facility if so desired to meet the needs of the facility.

The QA Committee will have ready access to the Medical Director of the facility as necessary. The Medical Director will be personally involved in effecting the resolution of the issues in the facility as identified.

F 520 Completed 7/15/14

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
--	--	--	---

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 520 Continued From page 19

to be interviewed pertaining to any issues, financial or otherwise, that might have been unresolved; a new Grievance Form was to be created to report issues to the Social Services Director (SSD); all staff were to be inservice on the new form and procedures by the SSD and Director of Nursing (DON); and, a grievance resolution was to be added to the agenda and monitored by the Continuous Quality Improvement (CQI) team in weekly meetings. However, the facility failed to ensure grievance resolution was added to the CQI team's agenda and failed to ensure it was monitored in the CQI weekly meetings. Interview and record review revealed resident interviews and staff education on the grievance process was not conducted and/or monitored per the POC. (Refer to F166)

Review of the POC revealed all staff were to have been inservice on abuse with emphasis on injuries of unknown origin and reporting. Compliance was to be monitored by the CQI team in weekly meetings with all allegations of abuse addressed and reviewed for completeness and accuracy of the handling of the allegation. However, the facility failed to ensure all staff received the abuse inservice education and failed to ensure documented evidence of the CQI team's monitoring as indicated in the POC. Review of the weekly (CQI) meeting notes for May 2014 revealed no documented evidence of the CQI team monitoring the inservice education and no documented evident the CQI team was discussing the inservice education in the weekly meetings. (Refer to F225)

Review of the facility's POC revealed all existing employees were to have received inservice education provided by the Social Services

F 520

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
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)
F 520	<p>Continued From page 20</p> <p>Director (SSD) and the Director of Nursing (DON) on all aspects of the facility's abuse policies and procedures. Continued review of the POC revealed the facility's compliance with the facility's policies and procedures was to be monitored by the DON, Minimum Data Set (MDS) Nurses and Administrator in the facility's weekly CQI. However, the facility failed to ensure all staff received the inservice education and failed to ensure documented evidence of the monitoring to have been performed by the DON, MDS Nurse and Administrator. Review of the May 2014 weekly CQI meeting notes revealed no documented evidence the DON, MDS Nurses or Administrator were monitoring to ensure staff's compliance with the facility's policies and procedures as indicated in the POC. Further review of the CQI meeting notes revealed no documented evidence the abuse policies and procedures inservice education was being reviewed or monitored by the CQI team in the meetings to ensure compliance was maintained. (Refer to F226)</p> <p>Review of the facility's POC revealed inservice education for all nursing staff was provided by the DON related to staff following the Comprehensive Care Plan. The POC revealed the DON and MDS Nurses were to monitor staff's compliance with following residents' Comprehensive Care Plans and the monitoring was to be addressed in the facility's CQI weekly meeting. However, the facility failed to ensure all nursing staff received the inservice education and failed to ensure documented evidence of the DON's and MDS Nurse's monitoring for compliance and that the monitoring was addressed in the CQI team's weekly meeting. Review of the facility's Quality Assurance (QA) Meeting Monitoring form</p>	F 520	

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
--	--	--	---

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 520

Continued From page 21

revealed it included previous deficiencies cited with questions, and "yes" and "no" areas to be checked. Continued review of the form revealed no documented evidence of monitoring to ensure the care plan inservice education was provided as per the POC, nor monitoring to ensure Comprehensive Care Plans were followed. (Refer to F282)

Review of the facility's POC revealed all nursing staff was to have been inserviced on lift equipment and proper transfer techniques by the DON. The POC revealed the DON and nurses were to monitor resident lifting procedure safety daily, and the CQI team was to monitor for compliance during weekly meetings. However, the facility failed to ensure all nursing staff had received the inservice education, and failed to ensure a process for the observations to monitor the resident lifting procedure was developed. Additionally, the facility failed to ensure documented evidence the CQI team monitored for compliance in the weekly meetings. (Refer to F323)

Interview, on 06/26/14 at 2:00 PM and 2:25 PM, with the MDS Nurse, who was a CQI team member, revealed she had not been aware she was responsible to help monitor staff's inservice education.

Interview, on 06/26/14 at 12:30 PM, with the DON, who was a CQI team member, revealed she had not monitored to ensure staff received the inservice education indicated in the POC. She stated she "thought" all the staff had received the inservice education; however, reported she had no system in place to track staff's inservice education attendance in order to monitor and

F 520

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2014
--	---	--	---

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 520 Continued From page 22
ensure staff had received the required education as per the POC.

Interview, on 06/25/14 at 1:00 PM and on 06/26/14 at 2:25 PM, with the Administrator revealed he had taken staff's "word" that they were completing the education and monitoring as per the POC. He stated he should have had a system in place to ensure the POC was implemented. The Administrator stated no audit tools were developed to monitor for implementation and effectiveness of the POC to correct the cited deficiencies. The Administrator further stated the facility's QA process was ineffective as the facility had not ensured "things" were completed "as we said they were".

F 520

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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)	YES: COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000 INITIAL COMMENTS F 000

A Recertification Survey was initiated on 05/06/14 and concluded on 05/08/14, with deficiencies cited at the highest Scope and Severity of a "G".

F 166 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO SS=D RESOLVE GRIEVANCES F 166

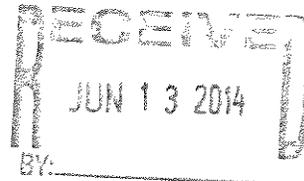
A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

This REQUIREMENT is not met as evidenced by:

Based on interviews, record review, and review of the facility's policy, it was determined the facility failed to resolve Unsampler Resident A's grievance with prompt efforts. The facility failed to actively seek a resolution and failed to keep Unsampler Resident A apprised of the follow-up related to the resident's report of six (6) dollars being missing.

The findings include:

Review of the facility's policy titled, "Dover Manor Grievance Policy", revised September 2013, revealed it was the policy of the facility to address grievances promptly. Further review revealed the Social Services Director (SSD) was to follow up on grievances with the appropriate departments, and all grievances/complaints were to be communicated on the daily log sheet. Continued review revealed the SSD was to pick up the log sheet each morning. In the absence of the SSD, the Director was to be notified by phone of any



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael Holden TITLE: Administrator DATE: 6/13/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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 000 INITIAL COMMENTS

F 000

A Recertification Survey was initiated on 05/06/14 and concluded on 05/08/14, with deficiencies cited at the highest Scope and Severity of a "G".

F 166 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES

F 166

A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

This REQUIREMENT is not met as evidenced by:

Based on interviews, record review, and review of the facility's policy, it was determined the facility failed to resolve Unsamped Resident A's grievance with prompt efforts. The facility failed to actively seek a resolution and failed to keep Unsamped Resident A apprised of the follow-up related to the resident's report of six (6) dollars being missing.

The findings include:

Review of the facility's policy titled, "Dover Manor Grievance Policy", revised September 2013, revealed it was the policy of the facility to address grievances promptly. Further review revealed the Social Services Director (SSD) was to follow up on grievances with the appropriate departments, and all grievances/complaints were to be communicated on the daily log sheet. Continued review revealed the SSD was to pick up the log sheet each morning. In the absence of the SSD, the Director was to be notified by phone of any

F 166 Although there was no verification from family or staff that Resident A had any money that could have been missing, the resident was given the \$6.00 in question and this seemed to relieve her anxiety over the situation.

Resident A was also interviewed by the Social Services Director regarding her general feelings of well-being in regard to the facility. She indicated that she had no fearfulness, that she wished to remain in the facility, and that she was quite satisfied overall. She was seen on 4/28, 4/29, 4/30, and 5/1, by the Social Services Director.

All residents in the facility capable of understanding the question were questioned pertaining to any issue, financial or otherwise, that may have been unresolved. None were expressed. All grievances brought forth to the facility have been resolved fully.

A new Grievance Form has been created for facility staff use to report to the Social Services Director, and a new log has been developed that will allow resolution of grievances to be followed at a glance.

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

TITLE

(X6) DATE

Michael C. Fuller Administrator 5/31/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 05/22/2014
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 05/08/2014
--	---	--	---

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)	% COMPLETION DATE
--------------------	--	---------------	---	-------------------

F 166 Continued From page 1
reported grievance. Further review of the policy revealed all grievances/complaints were to be reviewed by the Continuous Quality Improvement (CQI) Committee, and the Quality Assurance team was to review all grievances to ensure the process was completed.

Review of the medical record revealed Unsampld Resident A was admitted by the facility on 02/13/13. Review of the Brief Interview for Mental Status(BIMS), dated 02/12/14, review the resident scored a twelve (12), which indicated the resident was moderately cognitively impaired.

During the Group Interview, on 05/06/14 at 3:30 PM, Unsampld Resident A revealed he/she had six (6) dollars missing for approximately two (2) weeks. The resident stated he/she had reported the missing money but the facility had failed to follow up with the resident regarding a resolution.

Review of the Nurses Note, dated 04/25/14 at 10:00 PM, revealed Licensed Practical Nurse (LPN) #5 documented Unsampld Resident A reported six(6) dollars was missing from his/her change purse on 04/24/14. Continued review revealed LPN #5 notified the resident's daughter, who stated she would help look for the missing six (6) dollars when she came to visit the following day. Further review of the nurse's documentation revealed she searched the resident's room but the missing six (6) dollars was not found. LPN #5 documented she filled out a Missing Item Report and noted the resident's missing six (6) dollars on the "Daily Log".

Interview with the Director of Nursing (DON), on 05/08/14 at 11:30 AM, revealed she was aware of Unsampld Resident A's reported missing six (6)

F 166
F 166 Con't.
All staff have been in-serviced on new forms and procedures by Social Services Director on 5/13, 5/19, 5/28, 5/29, 5/30, and by the Director of Nurses on 5/14, and 5/27, 2014.
Grievance resolution has been added to the weekly CQI meeting agenda and compliance will be monitored in the weekly CQI meetings.
F 166 5/31/2014

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

PRINTED: 05/22/2014
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 05/08/2014
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 166 Continued From page 2

F 166

dollars. She directed the surveyor to discuss the incident with the SSD for further questions, as it was her responsibility to follow up on all grievances.

Interview with the SSD, on 05/08/14 at 11:35 AM, revealed she was aware of Unsampld Resident A's missing six (6) dollars, and she had notified the resident's daughter who was supposed to check to see if the missing money had come home accidentally in the resident's laundry. Further interview with the SSD revealed she had not heard back from the resident's daughter regarding the missing money. The SSD stated she could not remember the exact date she had contacted the daughter. She further stated she did not document in the resident's chart about contacting the daughter, nor had she completed any documentation regarding her investigation/follow-up related to the resident's missing six (6) dollars.

Subsequent interview with the SSD, on 05/08/14 at 4:00 PM, revealed whenever a resident reported missing an item or money, a Missing Items Report was to be completed by the staff person who received the initial complaint from the resident. However, she stated, staff did not always complete the Missing Items Report but would leave a note for the SSD on her desk. The SSD reported she did not receive a Missing Items Report for Unsampld Resident A's missing six (6) dollars, but did find a note on her desk about the incident. Further interview revealed no follow-up or investigation was done by the SSD after she notified the resident's daughter regarding the missing six (6) dollars. The SSD stated that an investigation should have been done and the investigation findings should have

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

PRINTED: 05/22/2014
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 05/08/2014
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)	AS COMPLETION DATE
--------------------	--	---------------	---	--------------------

F 166 Continued From page 3
been communicated with the resident.

Interview with the Administrator, on 05/08/14 at 4:20 PM, revealed he expected to see documentation in the resident's chart and on a grievance/missing items report any time a resident's belongings or money could not be found. Further interview revealed the process of an investigation and a resolution should have been documented in Unsampled Resident A's chart and on a grievance/missing items report regarding the missing six (6) dollars.

F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4)
SS=D INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

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.

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).

The facility must have evidence that all alleged

F 225 Resident #6 has been treated by her primary care Physician twice, by an orthopedic physician once, had x-rays, has been fitted for and received a strap-on splint, and her pain management efforts have been successful to the point that she has denied a need for pain medications on occasion.

Through observation and interview with residents no additional residents have been identified by the deficient practice. Interviews conducted by Social Services Director on 5/13, and 5/14, 2014.

Social Service Director conducted conducted interviews with all residents in the facility with a BIMS score of 8 or more. Residents unable to comprehend due to lack of cognitive function were not interviewed.

Abuse in-services have been conducted with all employees by the SSD on 5/13, 5/19, 5/28, 5/29, 5/30; and by the DON on 5/14 and 5/27, 2014, covering the necessity for reporting alleged violations within the facility and to regulatory agencies (immediately within the facility and within 24 hours to Regulatory agencies, investigation procedures and necessary corrective actions, prevention, identification, and protection of resident's safety once an allegation of abuse has been made.

In-services covered all aspects of abuse including, but not limited to, injuries of unknown origin. All existing employees have been in-serviced and all new employees will be educated on Abuse Policies and Pro-

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

PRINTED: 05/22/2014
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 05/08/2014
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)	% COMPLETION DATE	
F 225	Continued From page 4 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. 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 have an effective system in place to ensure injuries of unknown origin were immediately reported to the Administrator and appropriate State Agencies, and to ensure a thorough investigation was conducted in accordance with facility policy for one (1) of seventeen (17) sampled residents (Resident #6). On 04/23/14, Resident #6 experienced a fall during a transfer. On 04/24/14 through 04/26/14, prior to x-rays being obtained, Resident #6 experienced pain, redness and swelling to the right knee with no documented evidence of a cause for the injury of unknown origin. Further, the facility failed to conduct a thorough investigation of the injury or report the injury to the State Agency, per facility policy. The findings include: Review of the facility's policy titled, "Abuse Prevention Policy and Procedure", adopted	F 225	Employees not in compliance with training requirements will not be allowed to work in the facility until their in-services are made current. In-services also covered the use of Hoyer lift by nursing personnel, transfer of residents by both 1 and 2 persons, use of gait belts, and transfer sling. Accuracy of reporting suspected abuse was emphasized as well as the requirement for the DON, SSD, and ADM to be notified immediately. Additional in-services were conducted by the DON and Physical Therapist on 5/19, 5/20, and 5/22, addressing safe lifting techniques. In-services also addressed the issue of the towel lift, which has been eliminated as a means of transfer in the facility. Investigations of alleged abuse are initiated by the Social Services Director at the direction of the Administrator. The Social Services Director has received instruction in abuse investigation protocol from the Administrator and is fully familiar with the Regulatory requirements. A new manual has been crated entitled "Steps to be Taken When There is an Investigation in Place." This manual gives guidance regarding investigation requirements.		

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

PRINTED: 05/22/2014
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 05/08/2014
--	---	--	---

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 225 Continued From page 5
02/22/13, revealed it was the policy to ensure each resident was free of any type of abuse, neglect, or misappropriation of resident property while a resident in the facility. Each resident had the right to be free from abuse, corporal punishment, and involuntary seclusion. Any allegation of resident abuse required appropriate intervention to identify the event, investigate the allegation, protect all parties involved, report to the proper agencies, and prevent further occurrence of abuse. Further review of the policy revealed injuries of unknown origin were to be investigated and reported as potential abuse in accordance with the policy if the cause of the injury could not be determined with certainty.

Review of Resident #6's medical record revealed the facility re-admitted the resident on 04/13/12, with diagnoses including Senility, Osteoarthritis (a condition of chronic arthritis without inflammation), and Anemia. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 02/10/14, revealed the facility assessed Resident #6 as having a Brief Interview for Mental Status (BIMS) score of an eight (8) out of fifteen (15), indicating the resident was moderately impaired in cognition function. Further review of the MDS and the associated Comprehensive Care Plan, dated 02/10/14, revealed Resident #6 required the assistance of two (2) staff and a Hoyer (mechanical) lift for transfers.

Review of the Nurse's Notes, dated 04/23/14 at 17:15 and written by LPN #1, revealed aides reported while transferring Resident #6 to a geri-chair, the chair slipped behind the resident and the resident to scrape his/her shin on the metal part of the chair. Continued review of the

F 225 Compliance will be monitored in the weekly CQI Committee meetings. All allegations of abuse will be addressed in this weekly meeting and each will be reviewed by the CQI Committee for completeness and accuracy of handling in accordance with Regulatory requirements.

F225 6/10/14

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

PRINTED: 05/22/2014
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 05/08/2014
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)

F 225 Continued From page 6 F 225

Note revealed Resident #6 sustained a skin tear, measuring 1.0 centimeter (cm) x 0.1 cm as a result. Resident complained of pain in Right (R) knee and Tylenol was given. Further review revealed no documented evidence of an assessment of Resident #6's (R) knee was assessed by the nurse.

Review of the Nurse's Notes dated 04/24/14 at 10:30 AM revealed the Advanced Registered Nurse Practitioner (ARNP) was notified of the skin tear on left lower extremity. Continued review revealed the ARNP addressed the pain Resident #6 was having in the R knee.

Continued review of the Nurse's Notes revealed a late entry dated 04/24/14 at 7:15 AM, which indicated Resident #6 continued to complain of R knee pain and the knee was swollen. Tylenol was given for the pain. However, there was no documented evidence the swelling in Resident #6 was identified as an injury of unknown origin, or that the Administrator, Director of Nursing (DON) or State Agency was notified of the injury.

Review of the late entry in the Nurse's Notes, dated 04/24/14 at 3:00 PM, revealed Resident #6's daughter, and Power of Attorney (POA), was called related to the resident's knee pain.

Review of the Nurse's Notes dated 04/25/14 at 8:00 AM revealed Resident #6 complained of right leg pain, with Tylenol given.

Continued review of the Note on 04/24/14, revealed Resident #6's family voiced concerns about the edema (swelling) and warmth in the Resident's right knee and requested an x-ray be done. The nurse noted the family's request for the

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

PRINTED: 05/22/2014
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 05/08/2014
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)

F 225 Continued From page 7 F 225

x-ray was faxed to Resident #6's Physician. However, there was no documented evidence the Administrator, DON or State Agency was notified of the injury of unknown origin or of an investigation into the cause.

Review of the Nurse's Notes dated 04/26/14 at 9:00 AM revealed Resident #6 complained of pain in his/her right leg, but refused pain medication at that time. Review of the note at 10:40 AM revealed the ARNP was notified concerning the fax sent on 04/25/14 at 7:00 PM to the resident's Physician, and a new order was received for a Venous Doppler study of the right leg, secondary to the warmth and edema. However, there was no documented evidence the Administrator, DON or State Agency was notified of the injury of unknown origin or of an investigation into the cause.

Review of the Nurse's Notes dated 04/26/14 at 1:00 PM revealed Resident #6's POA called the facility upset, and stated a Certified Nursing Assistant (CNA) informed her the POA's sister, on 04/23/13, Resident #6 had been "dropped" while being transferred to the geri-chair. Continued review of the note revealed the POA demanded an x-ray of the right leg and the nurse informed the POA there was no report Resident #6 had been dropped during the transfer. Review of the Nurse's Notes at 2:40 PM, revealed Resident #6's Physician was contacted regarding the POA's request for an x-ray of the resident's right leg, and a new order was received for an x-ray of the knee, secondary to the knee being warm to touch and edematous. The portable x-ray company performed the exam at 6:00 PM. At 6:45 PM, the x-ray company called the facility to report Resident #6 had an Acute Nondisplaced

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

PRINTED: 05/22/2014
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 05/08/2014
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 225 Continued From page 8

F 225

Distal Femoral Fracture. Further review of the Nurse's Note revealed Resident #6's Physician was paged at 7:10 PM and again at 7:45 PM to inform him of the x-ray report. The Physician returned the call at 8:00 PM. Continued review of the Nurse's Note revealed the nurse informed the Physician Resident #6's POA wanted the resident transferred to the hospital for treatment and the Physician approved the request, with a telephone order written and faxed. Further review revealed Resident #6 was transported to the hospital as ordered.

Further record review revealed no documented evidence the facility notified the Administrator, DON or State Agency of Resident #6's injury of unknown origin, regarding the pain, redness and swelling of the R knee, prior to the resident being transferred to the hospital.

Interview, on 05/07/14, at 4:05 PM, with LPN #5 revealed she talked with CNA #3 on 04/25/14 concerning the incident with Resident #6 on 04/23/14. She stated CNA #3 revealed Resident #6 was being transferred to a geri-chair when the chair rolled backwards and Resident #6 was lowered to the floor. LPN #5 stated CNA #3 revealed she did not report this as a fall to LPN #1 who was working on 4/23/14. LPN #5 further stated she requested CNA#3 write a statement as to what transpired during the transfer. Continued interview revealed on 04/26/14 LPN #5 and LPN #1 were working together and LPN #5 told LPN #1 what CNA #5 reported had occurred during the transfer of Resident #6 on 04/23/14. LPN #5 stated the DON needed to be contacted regarding the incident and the DON was called between 3:30 and 4:00 PM on 4/26/14 and informed of Resident #6's fall. LPN #5 stated she

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

PRINTED: 05/22/2014
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 05/08/2014
--	---	--	---

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)	DATE OF COMPLETION
--------------------	--	---------------	---	--------------------

F 225 Continued From page 9
should have done something about the information she received from CNA #3 on 4/25/14 instead of waiting until 04/26/14, but stated she felt she did not have enough information. She indicated the DON should have been notified on 04/25/14 when she learned of the resident's fall.

Interview, on 05/08/14 at 6:23 PM, with the DON, revealed she was not made aware of the incident until 04/26/14. She stated at the time she was notified, an investigation was started and re-education was initiated immediately. The DON revealed the facility should have reported an injury of unknown origin to the State Agency.

F 226 483.13(c) DEVELOP/IMPLMENT SS=D ABUSE/NEGLECT, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

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 have an effective system in place to ensure policies and procedures were implemented related to injuries of unknown origin for one (1) of seventeen (17) sampled residents (Resident #6).

The facility identified swelling and redness to Resident #6's right knee beginning on 04/24/14; however, the facility failed to report the injury of

F 225
F 226 Resident #6 has been treated by her primary care Physician twice, by an orthopedic physician once, had x-rays, has been fitted for and received a strap-on splint, and her pain management efforts have been successful to the point that she has denied a need for pain medications on occasion.

All residents were assessed for any injuries that may have been of unknown origin per DON, MDS nurses, Staff nurses, on 5/9, and 5/12, 2014, and none were recognized.

F 226 Abuse in-services have been conducted with all employees by the SSD on 5/13, 5/19, 5/28, 5/29, 5/30; and by the DON on 5/14, and 5/27, 2014, covering the necessity for reporting alleged violations within the facility and to regulatory agencies (immediately within the facility and within 24 hours to Regulatory agencies, investigation procedures and necessary corrective actions, prevention, identification, and protection of resident's safety once an allegation of abuse has been made.

Special emphasis was placed on injuries of unknown origin, and upon the need for accuracy of reporting.

Employees not in compliance with training requirements will not be allowed to work in the facility until their in-services are made current.

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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 226 Continued From page 10
unknown origin or conduct an investigation to determine the cause of the injury, as per facility policy, until 04/26/14.

F 226

The findings include:

Review of the facility's policy titled, "Abuse Prevention Policy and Procedure", dated 02/22/13, revealed the facility was to ensure residents were free of abuse and neglect. The Policy and Procedure stated an injury of unknown origin was to be investigated and reported as potential abuse in accordance with the policy if the cause of the injury could not be identified. Continued review of the Policy and Procedures revealed residents were to be observed for signs of physical and verbal abuse and neglect such as "non-explained injuries". Further review revealed all allegations of abuse were to be reported immediately to the Charge Nurse, or one (1) of the following: Administrator, Director of Nursing (DON) or Social Services (SS) Director. Furthermore, reports were to be made within twenty-four (24) hours to the State Survey Agency after an allegation of abuse.

F 226 Con/t

All existing employees have been in-serviced and all new employees will be educated on Abuse Policies and Procedures to include injuries of unknown origin.

Employees not in compliance with training requirements will not be allowed to work in the facility until their in-services are made current.

Compliance will be monitored by the DON, MDS nurses, and ADM., and weekly in the CQI Committee meetings.

F 226

5/31/2014

Review of Resident #6's medical record revealed the facility re-admitted the resident on 04/13/12, with diagnoses which included Anemia, Osteoarthritis (chronic arthritis) and Senility. Review of the Significant Change Minimum Data Set (MDS) dated 02/10/14 revealed the facility assessed Resident #6 to be moderately cognitively impaired and to require two (2) person assistance with transfers.

Review of a Nurse's Note, dated 04/24/14 at 3:00 AM, revealed Resident #6 complained of pain to his/her right leg and there was swelling in the

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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 226 Continued From page 11

F 226

right knee. Continued review revealed a Note at 10:30 AM, which noted the Advanced Registered Nurse Practitioner (ARNP) was notified of Resident

#6's right knee pain with no new orders received, and the ARNP would examine the resident's knee on her next facility visit. Review of the 4/24/14 "late entry" Note timed 7:15 AM revealed Resident #6's right knee was swollen with no redness or warmth noted, and the resident complained of right knee pain. However, review revealed no documented evidence this information was reported to the State Agency and investigated as an injury of unknown origin as per the facility's policy.

Review of a 04/25/14 Nurse's Note, at 7:00 PM, revealed Resident #6's family members were "concerned" regarding the swelling and "warmth" in the resident's right knee and requested an x-ray be performed. Continued review of the Note revealed the Physician was notified by fax of the family's request.

Interview with Licensed Practical Nurse (LPN) #5, on 05/07/14 at 5:50 PM, revealed after shift report on 04/25/14 she assessed Resident #6's right knee and observed swelling (edema) and warmth to the area. However, according to LPN #5, Resident #6 had swelling in his/her right knee "a few months back" and staff had "not really thought too much about it". She stated family members visited Resident #6 on the evening of 04/25/14, and reported to her the resident was having "a lot of pain" in his/her right knee. LPN #5 stated she reminded the family members of Resident #6 having swelling in his/her right knee in January related to "fluid on the knee" which was painful. Record review and review of the

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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 226 Continued From page 12 F 226

facility's documentation revealed no documented evidence of an investigation to identify the cause of the swelling and warmth, or of it being reported to the State Agency as an injury of unknown origin.

Review of the Nurse's Note dated 04/26/14 timed 4:30 PM, revealed Resident #6's right knee continued to have edema (swelling) and remained "warm to touch" with complaints of pain in the right leg from the resident.

Further record review and review of the facility's documentation revealed no documented evidence an investigation to identify the cause of the swelling and warmth in Resident #6's right knee was performed, or that it was reported to the State Agency as an injury of unknown origin.

interview on 05/08/14 at 6:23 PM, with the DON, revealed she became aware of Resident #6's right knee pain, swelling and warmth on 04/24/14; however, she had not performed an investigation for an injury of unknown origin or reported it to the State Agency as such. She stated this was because staff thought it was the same thing which occurred in January, when the resident had fluid on his/her knee. The DON stated the facility would normally report an injury of unknown origin to the proper State Agencies. Further interview with the DON revealed she indicated the resident's swelling, warmth and pain to the right knee should have been reported as an injury of unknown origin and investigated as such because on 04/26/14 Resident #6 was diagnosed with a right femur fracture.

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED F 282
SS=6 PERSONS/PER CARE PLAN

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER DOVER MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 112 DOVER DRIVE GEORGETOWN, KY 40324
---	--

(X1) 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)	(X4) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282 Continued From page 13

F 282

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

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, it was determined the facility failed to ensure the Comprehensive Plan of Care was followed for one (1) of seventeen (17) sampled residents (Resident #6).

Resident #6 was care planned to be transferred per the Hoyer lift with assist of two (2) staff. However, on 04/23/14 two (2) Certified Nursing Assistants (CNAs) transferred Resident #6 using a "towel" method and the resident experienced a fall which resulted in a right Femur Fracture diagnosed in the hospital Emergency Room (ER) on 04/26/14.

The findings include:

Interview on 05/08/14 at 6:23 PM with the Director of Nursing (DON) revealed she indicated the facility had no policy for staff to follow residents' care plans, however, indicated she would expect staff to do so.

Review of Resident #6's medical record revealed the facility re-admitted the resident on 04/13/12, with diagnoses which included Osteoarthritis (a chronic arthritis condition), Anemia and Senility. Review of the Significant Change MDS Assessment, dated 02/10/14, revealed the facility assessed Resident #6 to be moderately

F 282 Resident #6 has been treated by her primary care physician twice, by an orthopedic physician once, had x-rays, has been fitted for and received a strap-on splint, and her pain management efforts have been successful to the point that she has denied a need for pain medications on occasion.

All residents were assessed for injuries of unknown origin that may have resulted from the same deficient practice, but none were identified. Assessments were completed per DON, MDS nurses, and staff nurses on 5/9 and 5/12, 2014.

The Care Plan for Resident #6 was revised on 5/9/2014 to eliminate towel lift and in-services were conducted by the DON and PT on 5/19, 5/20, and 5/22/2014, addressing safe lifting techniques.

A new procedure has been established that will ensure that orders are received by the MDS Nurses with certainty: A new fax machine has been installed in the MDS office and the MDS office has been added to the group notice of all orders faxed to pharmacy and physicians offices. The MDS nurses will continue to retrieve written orders each morning and will compare the faxed orders to the physical orders to make certain all orders have been received and are entered on the Care Plan.

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

PRINTED: 05/22/2014
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 05/08/2014
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 282	Continued From page 13 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the Comprehensive Plan of Care was followed for one (1) of seventeen (17) sampled residents (Resident #6). Resident #6 was care planned to be transferred per the Hoyer lift with assist of two (2) staff. However, on 04/23/14 two (2) Certified Nursing Assistants (CNAs) transferred Resident #6 using a "towel" method and the resident experienced a fall which resulted in a right Femur Fracture diagnosed in the hospital Emergency Room (ER) on 04/26/14. The findings include: Interview on 05/08/14 at 6:23 PM with the Director of Nursing (DON) revealed she indicated the facility had no policy for staff to follow residents' care plans; however, indicated she would expect staff to do so. Review of Resident #6's medical record revealed the facility re-admitted the resident on 04/13/12, with diagnoses which included Osteoarthritis (a chronic arthritis condition), Anemia and Senility. Review of the Significant Change MDS Assessment, dated 02/10/14, revealed the facility assessed Resident #6 to be moderately	F 282	Con't Our new procedure includes a duplication of all orders for all residents to be submitted to the MDS/Care Plan nurse. The new fax machine was installed in the MDS office on 5/28/14, and the MDS nurses were educated in regard to the new procedure on that date by the DON. This allows for a consistent double check system for placing orders on Care Plans and removing all old orders from existing Care Plans. Additional in-services were conducted by the DON regarding changes in procedure for Care Plans on 6/9, 6/10, 6/11, and 6/12, with all RNs, LPNs, KMAs, and CNAs. All nursing staff attended training. Compliance will be monitored by the DON in conjunction with the MDS nurses and addressed in the weekly CQI committee meetings.		
		F 282	6/13/14		

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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)	% COMPLETION DATE
--------------------	--	---------------	---	-------------------

F 282 Continued From page 15
CNAs assisted Resident #6 to the floor.

Interview, on 05/08/14 at 3:20 PM, with CNA #3 revealed she was not aware of what Resident #6's care plan stated regarding how the resident was to be transferred. She indicated she did not know she was supposed to use a Hoyer lift with Resident #6. CNA #3 revealed she had been told to transfer Resident #6 using a "towel transfer" which she indicated she had not been formally trained by the facility to do. However, review of the resident's Comprehensive Care Plan and the CNA's Care Plan revealed a Hoyer lift was indicated prior to 04/26/14. There was no intervention for a "towel transfer" on either care plan. Continued interview with CNA #3 revealed on 04/23/14, she and CNA #13 were trying to transfer Resident #6 from the bed to the geri-chair using a towel under the resident's knees and lifting under resident's arms, the "towel transfer". She stated she and CNA #13 were both holding under Resident #6's arms and holding the ends of the towel to transfer the resident and during the transfer the geri-chair began to roll backwards because it was not locked. CNA #3 further stated she and CNA #13 had to lower Resident #6 to the floor on his/her knees. She reported Resident #6 complained of pain in the right knee when they got him/her up off the floor into the geri-chair. Additionally, she stated Resident #6 had a skin tear on his/her leg; but, did not remember which leg.

Interview with CNA #13 was attempted per telephone contact on 05/08/14 at 9:53 am and again at 4:00 PM. No answer was received and the Surveyor was unable to leave a message either time as the voice mail indicated the voice mailbox had not been set-up.

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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 282 Continued From page 16

F 282

Interview, on 05/08/14 at 10:19 AM, with Licensed Practical Nurse (LPN) #1 revealed LPN #2 came to her on 04/23/14, and asked her to look at a skin tear on Resident #6's left lower leg. LPN #1 stated two (2) CNAs were present, CNA's #3 and #13, and informed her they had transferred the resident using the "towel method". the geri-chair had rolled and the resident hit his/her shin on the chair causing the skin tear. She stated the "towel method" transfer was one (1) staff person lifting a resident under his/her arms and another staff person lifting the resident's knees using a towel placed under the knees and then transferring the resident. She indicated she was not aware Resident #6 was still to be transferred per a Hoyer lift. LPN #1 stated staff transferred Resident #6 using the "towel method" because it was easier on the resident as he/she was afraid of the Hoyer lift.

Interview with LPN #2 on 05/08/14 at 4:30 PM. revealed he had assessed Resident #6's skin tear on 04/23/14 after the "aides" told him about it. LPN #2 stated LPN #1, who was the Charge Nurse that day, spoke to the CNAs regarding how the skin tear occurred; however, he did not hear what she was told by the CNAs. He stated he heard on 04/24/14, when he came to work. Resident #6 had a fall associated with when he/she received the skin tear. LPN #2 stated CNAs had care plan access which contained residents' "lifting procedure", and indicated CNA #3 and CNA #13 should have followed Resident #6's care plan.

Interview, on 05/08/14 at 5:40 PM, with CNA #11 and CNA #12 at 6:10 revealed they looked at residents' care plans to know how residents were

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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)	DATE COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282 Continued From page 17
to be transferred. CNA #11 indicated she used a Hoyer lift for residents if they were care planned for that and she had never used a "towel transfer and had never received training on how to perform it. CNA #12 stated if a resident's care plan stated to use a Hoyer lift, then she used the lift as per the care plan.

Interview, on 05/08/14 at 6:23 PM, with the DON revealed she learned of Resident #6's skin tear to the left shin which occurred on 04/23/14, during the morning meeting on 04/24/14. The DON stated Resident #6 had been care planned for use of a Hoyer lift, however, had become "fearful" of the Hoyer lift. She stated therefore, the facility had started using a "towel" to transfer him/her with. However, she indicated the facility had no formal training for the staff on performing the "towel" transfer. The DON reported because of Resident #6's fear of the Hoyer lift she thought it had been discontinued in January. She indicated the intervention to transfer Resident #6's per the Hoyer lift should have been discontinued from the resident's Comprehensive Plan of Care.

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

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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 323 Continued From page 18

Based on observation, interview, record review and review of the facility's Accident/Incident Report form and policy, it was determined the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for one (1) of seventeen (17) sampled residents (Resident #6).

Resident #6 was assessed by the facility to require the assistance of two (2) staff for transfers per the Minimum Data Set (MDS) Assessment dated 02/10/14. Review of the Comprehensive Plan of Care revealed Resident #6 was to be transferred per Hoyer lift. On 04/23/14, two (2) Certified Nursing Assistants (CNAs) attempted to transfer Resident #6 without the use of the Hoyer lift and the resident sustained a fall. The CNAs failed to report Resident #6's fall to the licensed nurse as per the facility's policy. Therefore, Resident #6 was not assessed by the licensed nurse after the fall and the resident continued to complain of right leg pain. On 04/26/14, Resident #6 was sent to the Emergency Room (ER) and diagnosed with a fracture of the right femur.

In addition, the facility failed to ensure the residents' environment remained free of accident hazards as evidenced by missing toilet bolt covers in three (3) resident bathrooms.

The findings include:

1. Review of the facility's, "Fall Assessment and Prevention" Policy, undated, revealed it was the policy of the facility to facilitate an interdisciplinary approach to care planning to prevent injuries, to appropriately monitor and assess a resident's status following a fall, and to accelerate the plan of care to address factors related to the incident.

F 323

F 323 The missing toilet bolt covers were replaced on the three toilets found on the date of the survey by the Maintenance Supervisor. All toilets in the facility were inspected at that time and any missing bolt covers were immediately replaced.

The Care Plan for Resident #6 was revised on 5/9/2014 to eliminate towel lift and in-services were conducted with CNAs, KMAs, and all Nurses by the DON and PT on 5/19, 5/20, and 5/22/2014, addressing safe lifting techniques.

In-services conducted by the DON on 5/14 and 5/27/2014 with all CNAs, KMAs, and Nurses covered the necessity to refer to the Care Plan for proper lifting procedure for each resident. Also covered were use of Hoyer lift, transfer by both 1 and 2 employees, use of gait belts, and transfer sling. Towel lift was eliminated as a means of transfer in the facility.

Toilet bolt covers are now being examined daily by Housekeeping Supervisor on her room inspection rounds. Resident lifting procedure safety will be monitored by Staff nurses and DON daily.

Compliance to be monitored weekly in CQI Committee meetings.

F 323 5/31/2014

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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)	DATE
--------------------	--	---------------	---	------

F 323 Continued From page 19

F 323

The Policy stated a "potential for injury" care plan would be initiated, when appropriate, based on the results of the Resident Fall Assessment. According to the Policy, an interdisciplinary care plan was to be individualized to reflect the specific needs and risk factors of the resident. Continued review of the Policy revealed all staff providing care to the resident were to be familiar with the care plan and the interventions necessary to provide for the resident's safety. The Policy indicated if a resident sustained a fall, the resident was not to be moved from the floor until a licensed nurse determined it was safe to do so. Further review revealed a licensed nurse was to immediately assess the resident after a fall and document the assessment and actions taken in the resident's medical record.

Review of Resident #6's medical record revealed the facility admitted the resident on 08/03/10, and re-admitted 04/13/12, with diagnoses which included Osteoarthritis (a condition of chronic arthritis without inflammation), Senility and Anemia.

Review of the Significant Change MDS Assessment, dated 02/10/14, revealed the facility assessed Resident #6 as having a Brief Interview for Mental Status (BIMS) of an eight (8) out of fifteen (15), indicating the resident was moderately impaired in cognition. Continued review of the MDS Assessment revealed Resident #6 was totally dependent on two (2) staff for transfers. Review of the Comprehensive Care Area Assessments (CAAs) dated 02/11/14, revealed Resident #6 was totally dependent on staff with ADLs and required total staff assist times two (2) with transfers. Further review of the CAAs revealed Resident #6 was to be

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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 323	Continued From page 20 "transferred with two (2) person assist" and would "proceed to" care plan. Review of the Comprehensive Plan of Care, initiated 11/13/13, revealed Resident #6 had a care plan for at risk for falls related to the resident being unaware of safety needs, having a balance problem, seizure disorder and history of a fall on 02/18/13. Continued review of the care plan revealed Resident #6 was to be transferred with a Hoyer (mechanical) lift for all transfers. Continued review of the Comprehensive Plan of Care revealed a care plan for Resident #6's Activity of Daily Living (ADL) self-care deficit in regards to his/her diagnosis of Dementia, limited mobility and impaired balance. Review of the interventions for the ADL care plan revealed Resident #6 was totally dependent of staff for transferring, two (2) person assist with transfers. Review of the CNA Care Plan, dated April 2014, revealed under the "transfer section", mechanical lift/Hoyer and assist times two (2) were checked. However, continued review revealed these transfer interventions were marked through with a line and there was no documented evidence of a date to indicate when the interventions were discontinued. Further review revealed the Transfer Section was revised on 04/26/14 and 04/27/14. Review of the facility's Accident/Incident Report form, undated, revealed on 04/23/14 at 5:15 PM, Licensed Practical Nurse (LPN) #2 had reported to LPN #1 that CNA #3 and CNA #13 told him they were getting Resident #6 out of bed when the geri-chair "slipped out from under aids due to lock not locking". Continued review of the Accident/Incident Report form revealed Resident	F 323		
-------	--	-------	--	--

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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 323 Continued From page 21 F 323

#6 "hit" his/her shin on the "metal bar on side of chair, knees buckled". Further review of the Accident/Incident Report form revealed no documented evidence Resident #6 had experienced a fall.

Review of the Nurse's Notes, dated 04/23/14 at 5:15 PM, revealed Resident #6 was up in his/her geri-chair and the CNAs had reported when transferring the resident the geri-chair "slipped behind" him/her. Review of the Note revealed this had "caused" Resident #6 to "scrape" his/her shin on the "metal part" of the geri-chair. The Note revealed Resident #6 had a 1.0 centimeter (cm) by 0.1 cm skin tear to the lower left shin area which was cleansed by Licensed Practical Nurse (LPN) #2 and a steri-strip applied to the skin tear. Continued review of the Note revealed Resident #6 complained of pain in his/her leg and Tylenol (a non-narcotic pain reliever) was administered and the nurse would continue to monitor. There was no documented evidence of which leg Resident #6 complained of pain in. Review of the Note revealed Resident #6 was taken to the dining room "for dinner". Continued review of the Nurse's Notes revealed a Note timed 5:45 PM, which stated Resident #6 was taken back to his/her room as requested because of complaints of pain and the resident "immediately" closed his/her eyes and stated he/she just wanted "to rest".

Interview on 05/08/14 at 3:20 PM with CNA #3, revealed she and CNA #13, had been transferring Resident #6 on 04/23/14 with the use of a towel under his/her knees. She stated she and CNA #13 each held the ends of the towel and Resident #6's arms to transfer the resident to the geri-chair. CNA #3 stated the geri-chair was not

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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 323 Continued From page 22

locked in place and rolled backwards and they had to "assist" Resident #6 to the floor on his/her knees. She stated they then lifted the resident and assisted him/her to the geri-chair. CNA #3 stated she had not been trained on how to perform a "towel transfer"; however, that was how she was told to get Resident #6 up. However, review of the CNA Care Plan revealed a Hoyer lift was indicated as the method for transfer for Resident #6, prior to 04/26/14. CNA #3 stated she knew a fall was anytime a resident went to the floor assisted or not. She stated she knew the CNAs were to go get a nurse before moving a resident after a fall. CNA #3 indicated they were in "just such a spur of the moment" and did not think to get the nurse as per the policy. She stated she did not know what Resident #6's care plan said regarding how he/she was to be transferred, and indicated she did not know she was supposed to be getting the resident up with a Hoyer lift. CNA #3 reported Resident #6 had a skin tear on his/her leg; however, could not recall which leg. She stated Resident #6 complained of pain to his/her right knee after they got him/her in the geri-chair. According to CNA #3, they transported Resident #6 in the geri-chair to the dining room for dinner where he/she continued to complain of right knee pain. CNA #3 stated they told LPN #1 and LPN #2 that Resident #6 was in pain, had a skin tear and they had assisted him/her to the floor. She stated they did not say "fall" when telling the nurses of assisting Resident #6 to the floor. Continued interview with CNA #3 reported the nurses did not ask any questions in regards to the fall after they explained the incident to them. She stated she did not work on 04/24/14, did return to work on 04/25/14 and Resident #6 complained of his/her right knee hurting and "moaning" all of her shift.

F 323

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

PRINTED: 05/22/2014
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <p style="text-align: center;">185295</p>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <p style="text-align: center;">05/08/2014</p>
--	---	--	---

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)	% COMPLETION DATE
--------------------	--	---------------	---	-------------------

F 323 Continued From page 23

F 323

Interview on 05/08/14 at 10:19 AM, with LPN #1 revealed on 04/23/14, LPN #2 came to her and asked her to go to Resident #6's room because the resident had a skin tear on his/her left leg. She stated she went to Resident #6's room and CNA #3 and another CNA, CNA #13, told her they were transferring the resident from the bed to the geri-chair using the "towel method" and the geri-chair "rolled back to the wall". LPN #1 stated the CNAs told her Resident #6's "knees buckled" and one (1) of them "grabbed" the geri-chair and they put the resident in the geri-chair. She stated the CNAs did not "say" Resident #6 "fell to the floor". According to LPN #1, the "towel method" involved one (1) person getting "under the arms" of a resident and the other person lifting the resident's knees with a towel and they transferred the resident that way. LPN #1 stated a fall was considered "anytime a person's body" went to the floor, except if it was the bottom of the person's feet which touched the floor. She indicated she "charted" what she had been told by the CNAs "at the time", in Resident #6's medical record. Additional interview on 05/08/14 at 10:30 AM, with LPN #1 revealed "at no time" had the CNAs reported to her Resident #6 was assisted to the floor. She stated on 04/26/14 at 3:00 PM was the first time she had heard anything about Resident #6 being assisted to the floor on 04/23/14. LPN #1 stated CNA #3 wrote a statement on 04/26/14 regarding Resident #6 being assisted to the floor on his/her knees. She stated CNA #3 and CNA #13 stated "it was miscommunication between themselves and me". LPN #1 indicated she had re-educated the CNAs on the protocol for falls to included notifying the nurse so an assessment could be performed; however, did not have "them sign anything".

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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 323 Continued From page 24

F 323

Interview on 05/08/14 at 4:30 PM with LPN #2, revealed on 04/23/14 the "aides" came and got him to "check out" a skin tear "they had". He stated he thought it was after dinner and that was all the "aides" had told him about. He reported he told the Charge Nurse, LPN #1 who talked to the CNAs "about what happened" to cause the skin tear and he did not hear what the "aides" told the Charge Nurse. Continued interview with LPN #2 revealed he worked the "next day", 04/24/14 he thought, and that was when he "heard there was a fall" associated with the skin tear. He stated he was not certain who had told him; but, indicated he was told CNA #13, who had assisted with the transfer and had informed Resident #6's family the resident had "fallen". According to LPN #2, he had never used "a towel lift" or seen it used; however, knew it involved a towel under the knees and under the arms" and then lift. LPN #2 indicated the CNAs had access to the care plan which had each resident's "lifting procedure" on it and they should follow it.

Interview on 05/07/14 at 5:50 PM with LPN #5, revealed she had worked on 04/24/14, 04/25/14 and 04/26/14, on the 3:00 PM to 11:00 PM shift. She stated on 04/25/14, she asked CNA #3 what had happened to Resident #6 on 04/23/14. LPN #5 stated CNA #3 told her when she and CNA #13 transferred Resident #6 from the bed to a "new" geri-chair that was not locked which rolled and the "towel" they were using for the transfer "slipped" and they assisted the resident to the floor. She stated CNA #3 reported Resident #6 obtained the skin tear at that time also. According to LPN #5, she asked CNA #3 if she realized assisting the resident to the floor was considered a fall. She stated CNA #3 said "yes,

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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)	% COMPLETION DATE
--------------------	--	---------------	---	-------------------

F 323	Continued From page 25 she knew it was a fall" however, had not reported the fall to LPN #1. LPN #5 told CNA #3 to write a statement as to what happened on 04/23/14, which she indicated CNA #3 had done.	F 323	
-------	---	-------	--

Review of CNA #3's written statement dated 04/26/14, revealed she and CNA #13 were transferring Resident #6 from the bed to a geri-chair, which was new to the resident. Review of the written statement revealed CNA #3 and CNA #13 sat Resident #6 up on the side of the bed, placed a towel under his/her knees and proceeded to transfer the resident to the geri-chair. Continued review of the written statement revealed the geri-chair was not locked and the chair slid out from under the resident causing the towel to slip and the CNAs had to assist Resident #6 to the floor.

Interview with CNA #13 was attempted per phone contact on 05/08/14 at 9:53 AM and 4:00 PM; however, no answer was received and a message could not be left as the recording indicated the voice mailbox had not been set-up.

Continued interview on 05/07/14 at 5:50 PM with LPN #5, revealed on 04/26/14 she had spoken to LPN #1, who also had worked on 04/23/14, and asked her what had happened to Resident #6 that day (04/23/14). LPN #5 stated LPN #1 told her Resident #6 had received a skin tear to his/her left shin during a transfer and she (LPN #1) had completed an Incident Report on 04/23/14 in regards to the skin tear. According to LPN #5, LPN #1 reported LPN #2 had performed the treatment on Resident #6's skin tear. She stated she informed LPN #1 what CNA #3 had reported to her regarding Resident #6 sustaining a fall during the transfer.

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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 323 Continued From page 26

F 323

Review of a Nurse's Note dated 04/24/14 at 3:00 AM, revealed Resident #6 complained of pain to his/her right leg and there was "edema" in the right knee. However, Resident #6 refused pain medication. Review of a Nurse's Note dated 04/24/14 at 7:10 AM, revealed a "late entry" for 3:00 AM, which stated Resident #6's right knee was "edematous" with "+3" (significant) "edema" noted. Continued review of the 04/24/14 Nurse's Notes revealed at 10:30 AM, the nurse documented the Advanced Practice Registered Nurse (APRN) was notified of the skin tear on Resident #6's left lower extremity and approved of the treatment. Review of the Note revealed the APRN was also notified of the right knee pain Resident #6 was having, no new orders were received and the nurse documented the APRN was to "look at" the resident's knee on her next visit.

Review of the 4/24/14 "late entry" timed 7:15 AM, revealed Resident #6 complained of right knee pain and the knee was swollen, with no redness or warmth noted. Continued review of the "late entry" Note revealed Tylenol was administered and the nurse would continue to monitor. The "late entry" Note revealed at 1:30 PM, Resident #6 complained of right knee pain and Tylenol was administered. Further review of the "late entry" Note revealed at 3:00 PM, Resident #6's daughter was notified related to the resident's complaints of right knee pain and that "PRN" (as necessary) pain medications were being administered to "control" the pain. The "late entry" Note indicated the resident's daughter was "agreeable" with "all".

Interview on 05/07/14 at 5:50 PM with LPN #5,

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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 323 Continued From page 27

F 323

revealed she received in report on 04/24/14 information regarding Resident #6 having a skin tear on his/her left shin which occurred during a transfer on 04/23/14. LPN #5 stated she did not have to administer any PRN pain medication to Resident #6 on 04/24/14. LPN #5 reported one (1) of Resident #6's daughters had inquired what had happened the "night before" and she informed the daughter she had not worked on 04/23/14.

Review of a 04/25/14 Nurse's Note, timed 8:00 AM, revealed Resident #6 complained of right leg pain and PRN Tylenol and the nurse would continue to monitor. At 9:20 AM, the nurse documented Resident #6 was "resting in bed" with no signs and symptoms of "distress" noted. Review of the 04/25/14 Nurse's Note, timed 7:00 PM, revealed Resident #6's family was "concerned" about the "edema" and "warmth" in his/her right knee. Continued review of the Note revealed the family was requesting an x-ray and the Physician was notified of the request.

Continued interview with LPN #5,m on 05/07/14 at 5:50 PM revealed on 04/25/14, during shift report, she was told Resident #6 had "swelling" in his/her right knee and "yelled out" in pain during the previous shift and Tylenol had been administered. LPN #5 reported she believed Resident #6's pain was addressed with the APRN, however, could not recall how she knew this information. Continued interview with LPN #5, revealed Resident #6 had experienced "some" swelling in his/her right knee "a few months back" and therefore, no one "really thought too much about it". She stated she assessed Resident #6 after shift report on 04/25/14, and found swelling and warmth to the

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

PRINTED: 05/22/2014
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 05/08/2014
--	---	--	---

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)	DATE
--------------------	--	---------------	---	------

F 323 Continued From page 28

F 323

resident's right knee. LPN #5 stated she asked the medication technician (med tech) to administer Tylenol to Resident #6 during the next medication pass. She stated one (1) of Resident #6's sons and another daughter were visiting on the evening of 04/25/14, and made reference to the resident having "a lot of pain" in his/her knee and they had been told he/she had been "dropped". LPN #5 stated she told Resident #6's son and daughter there was no documentation of the resident sustaining a fall and stated she reminded them of his/her right knee "swelling in January from fluid on the knee". She reported she told them "fluid on the knee" was painful and she could ask the Physician for an order for an x-ray. LPN #5 stated Resident #6's son told her it would be okay to ask the Physician the next morning for an x-ray of the knee.

Review of the Nurse's Note dated 04/26/14 at 10:40 AM, revealed the nurse spoke with the APRN regarding the fax to the Physician related to Resident #6's family's concern about his/her right knee edema and warm to touch and request for an x-ray. Continued review of the Note revealed a new order was received for a "venous doppler" (ultrasound) of Resident #6's right leg secondary to warm to touch and edema. Resident #6's Power of Attorney (POA) was notified of this information per the nurse's documentation.

Interview on 05/08/14 at 4:05 PM with Licensed Practical Nurse Applicant (LPNA) #4 revealed she was the Charge Nurse on 04/26/14 and had spoken to the APRN about the fax to the Physician for an x-ray of Resident #6's right knee and about the family's concerns. She stated the APRN ordered a "venous doppler" instead of an

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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 323 Continued From page 29

F 323

x-ray, as she (LPNA) thought Resident #6's right knee edema might have been related to a Deep Vein Thrombosis (DVT), a blood clot. LPNA #4 stated she called the portable x-ray company and gave them the order for the "venous doppler". According to LPNA #4, the portable x-ray company called back and said they could not come to do the ordered "doppier" until 04/28/14.

Continued review of the 04/26/14 Nurse's Notes revealed at 11:20 AM, Resident #6 continued to complain of right leg pain and PRN Tylenol was given. Review of the Nurse's Note dated 04/26/14 at 1:00 PM, revealed Resident #6's POA called "upset/crying" and stated her sister had told her the night "after" the skin tear incident happened, she was at the facility when an "aide" told her Resident #6 was "dropped" when the geri-chair "slid" and his/her right leg "buckled" at that time. The Note revealed Resident #6's POA was "demanding" an x-ray be performed of the resident's right leg. Continued review of the Note revealed the POA informed the nurse: there was "neglect" going on in the facility; the "aides" should not have "dropped" Resident #6; and the "aides" should have been "less worried about that chair". The nurse documented in the Note she told Resident #6's POA she "got no report of" the resident "being dropped" and had read through the medical record and there was nothing charted. Further review revealed a Note timed 1:29 PM, which revealed the nurse had notified the facility's Social Worker (SW) regarding what the POA had said and the SW was to call the POA. Review of a Note timed 1:40 PM, revealed the SW called the nurse back and informed her the family wanted an x-ray.

Continued interview on 05/08/14 at 4:05 PM with

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

PRINTED: 05/22/2014
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 05/08/2014
--	---	--	---

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 323 Continued From page 30 F 323

Licensed Practical Nurse Applicant (LPNA) #4 revealed Resident #6's POA called her on 04/26/14, "crying and upset" and told her another daughter had visited the resident 04/24/14. Continued interview with LPNA #4 revealed Resident #6's POA reported the daughter who visited on 04/24/14, was told by a CNA the resident was "dropped" on 04/23/14 when he/she obtained the skin tear. LPNA #4 stated she called the facility's Social Worker (SW) on 04/26/14 and informed her of what Resident #6's POA had told her regarding being upset because the "aides were neglecting" the resident.

Review of the 04/26/14 Nurse's Note at 2:30 PM revealed the nurse notified the Physician regarding the POA's request for an x-ray and received a new order for an x-ray of Resident #6's right knee.

Further interview on 05/08/14 at 4:05 PM with LPNA #4 revealed she had "paged" the Physician at 2:30 PM and the Physician returned her call and ordered the x-ray.

Review of the Nurse's Note dated 04/26/14 timed 4:30 PM, revealed a nurse documented Resident #6's right knee remained "swollen and warm to touch" and he/she had complaints of pain to the right leg. Continued review of the Note at 4:30 PM, revealed Resident #6 did not want to be moved or repositioned. Review of the Note timed 5:30 PM, revealed Resident #6 was "yelling in pain when transferred to geri-chair" and the nurse attempted to give Tylenol which the resident "spit out". Review of the Nurse's Note timed 6:00 PM revealed the portable x-ray company was at the facility to perform the x-ray and Resident #6 had "refused dinner and fluids". Review of the Note

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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)	DATE COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323 Continued From page 31 F 323

timed 6:45 PM, revealed the nurse noted the x-ray report had been received and revealed an "acute nondisplaced femoral fracture". Further review of the Nurse's Notes revealed at 7:10 PM, the Physician was notified; a Note at 8:00 PM revealed the nurse noted the Physician called back and she went over the x-ray report with him. Continued review of the 8:00 PM Note revealed the nurse documented the Physician ordered Resident #6 sent to the ER. Review of the Nurse's Note timed 8:30 PM revealed Resident #6 was sent to the ER via ambulance.

Review of the Hospital ER Physician Documentation, dated 04/26/14, revealed Resident #6 was diagnosed with a fracture of the "distal" right femur and a "knee immobilizer" was placed. Continued review of the ER Physician Documentation revealed Resident #6 was discharged back to the facility on 04/26/14 at 9:58 PM in stable condition with narcotic pain medication ordered.

Further interview on 05/07/14 at 5:50 PM with LPN #5, revealed on 04/26/14 she informed LPN #1 they needed to call the Director of Nursing (DON) and see what needed to be done. She stated the DON was called between 3:30 PM and 4:00 PM, everything she had learned was reported to the DON. LPN #5 stated the DON talked to LPN #1 and was also going to talk to the day shift nurse, LPNA #4 to "see how the family was that day". LPN #5 indicated she should have "done something" on 04/25/14 after learning of Resident #6's fall, such as, contacting the Physician; however, did not feel she had enough information at that time.

Interview on 05/08/14 at 6:23 PM with the DON,

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

PRINTED: 05/22/2014
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 05/08/2014
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)	NO. COMPLETION DATE
--------------------	--	---------------	---	---------------------

F 323 Continued From page 32

F 323

revealed she knew an incident occurred on 04/23/14 during a transfer of Resident #6 when he/she sustained a skin tear to the left shin which she had learned about during morning meeting on 04/24/14. She stated she and a day shift LPN went and assessed Resident #6's skin tear and right knee for bruising and swelling. She reported they also reviewed Resident #6's medical record which revealed Resident #6 had experienced pain and swelling in the right knee in January, 2014. The DON stated at that time they thought they just had a "bump and buckle of the knee", nothing more because of having the same problem in January. Continued interview with the DON revealed on 04/24/14, the APRN was notified of Resident #6's right knee being swollen, warm to touch and painful. She stated LPN #5 should have contacted the Physician on 04/25/14 after she learned of Resident #6's fall; however, had not contacted anyone including herself until 04/26/14. The DON stated she should also have been contacted on 04/25/14 so she could investigate and re-educate as necessary. She stated the facility had training for staff on transfers including the use of gait belts and Hoyer lifts. The DON reported Resident #6 had been a Hoyer lift, but became "fearful" of the lift and the facility had initiated transferring him/her with a "towel". According to the DON, she thought the Hoyer lift had been discontinued in January because the resident "feared it". However, she indicated the facility had no formal training for CNAs to determine they could safely transfer residents using the "towel" method. She stated "new aides" were trained on the "towel" method by their co-workers. The DON stated Resident #6's Comprehensive Plan of Care should have been revised to discontinue the Hoyer lift and add the "towel" transfer method. The DON stated she

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

PRINTED: 05/22/2014
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 05/08/2014
--	--	--	--

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)	ACT COMPLETION DATE
--------------------	--	---------------	---	---------------------

F 323 Continued From page 33 F 323

expected the staff to follow the Care Plans. Record review revealed the Hoyer lift was listed as an intervention on the Comprehensive Care Plan and the CNA Care Plan prior to 04/26/14.

2. Observation of the facility on 05/08/14 at 11:10 AM, revealed there were no bolt covers on the toilets in room 18, room 37, and room 44.

Interview with the Maintenance Supervisor on 05/08/14 at 3:20 PM, revealed bolts should be covered on the toilets. He stated it was his responsibility to ensure the toilet bolt covers were in place. The Maintenance Supervisor stated he had a log for repairs; however he had not been "keeping up with it".

Interview with the Administrator on 05/08/14 at 3:35 PM, revealed maintenance was responsible for checking areas regarding the bolts on the toilets to ensure residents were safe using the bathroom. The Administrator stated he expected everyone in the facility to be responsible for the upkeep and report to him when they noticed areas of concern. Further interview with the Administrator revealed the missing bolt covers placed residents at risk, as not having the bolts covered, could cause a skin tear or cut. The Administrator revealed "ultimately" it was his responsibility to ensure all fixtures were safe for residents.

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

PRINTED: 07/22/2014
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 B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2014
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

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: 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 05/07/14. The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) at req. (Life Safety from Fire)

RECEIVED
BY: JUN - 2 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Michael J. Adams, Administrator

TITLE
Administrator

(X6) DATE
5/31/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.