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

PRINTED: 03/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED
	185295		C 03/12/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY#00017942 was initiated on 03/12/12 and concluded on 03/12/12. The allegation was substantiated with deficient practice cited.	F 000	RECEIVED APR 20 2012	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services 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 observation, interview and record review, it was determined the facility failed to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of one (1) of three (3) sampled residents (Resident #1). The facility was not able to provide any documented evidence that social services consulted and worked with Resident #1 after an alleged allegation of abuse until two (2) days after the event had occurred. The findings include: Review of Resident #1's clinical record, revealed the facility admitted Resident #1 on 05/06/05, with diagnoses which included Cerebrovascular Disease, Late Effects of Hemiplegia, Depressive Disorder, Osteoporosis, and Malaise/Fatigue. Review of Resident #1's clinical record, revealed	F 250	F250 The incident in question has been discussed with Resident #1 by the Social Services Director on numerous occasions as stated in the SOD. The failure was in not documenting those discussions. The Social Services Director has continued with her discussions with the resident pertaining to the incident of 2/24/12, as well as to her general well-being and those discussions have been documented. Discussions took place on 3/15, 3/16, 3/17, 3/18, and 3/19/2012. Social Services notes have been completed on all residents requiring medically-related services. No additional residents lacking in necessary medically-related social services have been identified. Social Services Director has been in-serviced by Director of Nursing and Administrator regarding necessity for documentation on 3/15, 3/17, and 3/19/2012. All department heads and nursing staff have been instructed to report need for social service intervention to Social Services Director immediately. Social Services Director shall document interaction and interventions with residents as required. Compliance will be monitored in Weekly Care Plan meetings, weekly CQI meetings, and by Director of Nursing.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Fulden	Administrator	4/20/12

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

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NAME OF PROVIDER OR SUPPLIER: DOVER MANOR

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F 250	Continued From page 1 the facility developed a Plan of Care, 12/21/11, for ineffective coping related to history of not adjusting well to change, related to Anxiety, Depression, Psychosis and a history of Personality Disorder. Interventions included, be supportive, allow resident to voice any feelings or frustrations, and to be pleasant and provide a positive atmosphere. Record review of the facility's investigation revealed on 02/24/12, it was witnessed a State Registered Nursing Assistant (SRNA) #3 told Resident #1, "if you ring that call light one more time, I am going to take it away from you." After the witnesses reported the incident, SRNA #3 was immediately sent home pending the investigation. Interview with SRNA #1, on 03/12/12 at 3:00 PM, revealed she recalled the incident on 02/25/12, when she was counting narcotics with the pharmacy delivery guy and another staff member, she overheard SRNA #3 tell Resident #1, that if he/she rang the call bell one more time that she was going to take it away from him/her. Further interview revealed SRNA #1 reported the incident to the Charge Nurse immediately. Interview with SRNA #3, on 03/12/12 at 3:45 PM, revealed she remembers the incident as she was counting narcotics when the incident occurred. Further interview revealed, the incident was immediately report to the Charge Nurse and that SRNA #3 was sent home. Interview with Resident #1, on 03/12/12 at 4:00 PM, revealed at the time of the incident, it made him/her feel sad that staff would not want to help	F 250 F250	CQI Committee is comprised of the Director of Nursing, Administrator, All Department heads, random added employees from each department, Pharmacy (Quarterly) and our Medical Director. **Completed 3/20/2012**	

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F 250	Continued From page 2 out in a time of need. Continued interview revealed staff did not address his/her feelings at the time of the alleged abuse allegation. Review of the Social Services notes revealed no documented evidence related to the incident until 02/27/12. Interview with the Social Services Worker #1, on 03/12/12 at 4:00 PM, revealed she did speak with Resident #1 on the date of the incident (02/24/12), however, no documented evidence could be located. Further interview, revealed the Social Services Worker #1 spoke with Resident #1 on 02/27/12. Continued interview revealed she had talked with Resident #1 but could not provide any documented evidence of her time spent with Resident #1, but she should have documented anything discussed with Resident #1 regarding the situation and should have ensured Resident #1 felt safe and secure at the facility. In addition, Social Services Worker #1 stated she should have ensured the stability of Resident #1's psychosocial status related to the incident on the day of the incident. Interview with the Director of Nursing, on 03/12/12 at 4:30 PM, revealed she could not locate any documented evidence in the clinical record where Social Services had provided measures to Resident #1 related to the incident on 02/24/12 until 02/27/12. Further interview revealed Social Services should have been proactive in providing services to Resident #1. Interview with the Administrator, on 03/12/12 at 5:00 PM, revealed he had instructed Social Services Worker #1 to follow-up with Resident #1 frequently since the allegation had been alleged. Further interview revealed the Administrator	F 250		

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F 250	Continued From page 3 would have expected Social Services Worker #1 to document her visits and conversations with Resident #1.	F 250		