

PRINTED: 09/06/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/26/2011
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NAME OF PROVIDER OR SUPPLIER DOVER MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 112 DOVER DRIVE GEORGETOWN, KY 40324
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(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
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F 000 F 323 SS-D	<p>INITIAL COMMENTS</p> <p>An Abbreviated Surevey investigating ARO#KY00016930 and ARO#KY00016935 was initiated on 08/24/11 and concluded on 08/26/11. ARO#KY00016930 was substantiated with deficient practice identified at 483.25 Quality of Care with a scope and severity of a "D". ARO#KY00016935 was substantiated with no deficient practice identified.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure each resident received adequate supervision and assistance to prevent injury for one (1) of five (5) sampled residents, Resident #2. Resident #2 sustained a bruise to the right breast. The facility failed to use an interdisciplinary approach to develop, implement and evaluate interventions to prevent additional injury.</p> <p>The findings include: Review of the Clinical Record revealed the facility</p>	F 000 F 323	<p>F323 The resident referenced in the SOD has been evaluated for transfer safety, positioning safety, and general safety as it pertains to her care. Staff has been educated by both the Director of Nursing and Physical Therapists through in-service and example.</p> <p>Custom-padded gait belts have been obtained for the resident for safer transfers.</p> <p>The resident is now required to wear a brassiere at all times to help positioning of her body.</p> <p>In-services have been conducted by PT and the Director of Nursing on 8/30, 9/1, 9/3, and 9/5/11, to address transferring and positioning safety for this resident and all other residents in the facility.</p> <p>The condition of the resident involved is being monitored on a daily basis by nursing staff and her condition is reported to the Director of Nursing.</p> <p>All residents in the facility have been evaluated for similar unsafe conditions, but none were noted. Review and evaluation of residents were conducted on 8/30, 9/1, 9/3, and 9/5/11, by the Director of Nursing, Sherry Thomas, RN, Jamie Pierce, LPN, and Patricia Pearson, RN.</p>	
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BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Michael J. ...* TITLE: *Administrator* DATE: *9/6/11*

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/26/2011
NAME OF PROVIDER OR SUPPLIER DOVER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 112 DOVER DRIVE GEORGETOWN, KY 40324		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 1</p> <p>admitted Resident #2 on 07/12/07 with diagnoses which included Dementia, Seizure Disorder, Anemia and Thrombocytopenia. Review of the annual Minimum Data Set (MDS) Assessment, dated 05/11/11, revealed the resident was dependent on staff for all care.</p> <p>Review of the Nurses Notes, dated 08/15/11, revealed Resident #2 was found to have a bruise on the right breast. Review of the facility investigation revealed the facility determined the bruise occurred in one (1) of two (2) ways: improper positioning of the gait belt; or the breast became pinched under the resident's arm during turning and repositioning.</p> <p>Review of the Comprehensive Care Plan, update of 08/15/11, revealed no specific interventions were initiated to promote proper positioning of the gait belt or to protect the breast from pinching under the arm.</p> <p>Interview with Certified Nursing Assistant (CNA) #4, on 08/26/11 at 10:05 AM, revealed she took care of Resident #2 frequently and was familiar with her care needs. She stated she was not aware of any changes in the way the resident was to be cared for. She further stated there had not been any inservice training since the incident occurred.</p> <p>Interview with CNA #2, on 08/26/11 at 11:15 AM, revealed she was familiar with Resident #2 and cared for her frequently. She stated the Care Guide, used by the CNAs to direct the care of the residents, had not been updated since the bruise was discovered. Continued interview revealed there had been no training since the incident</p>	F 323	<p>Nursing staff have been in-serviced on the necessity for residents to wear appropriate clothing when required, transferring safety, need to involve PT early upon recognition of potential for harm to any resident during the transfer process, as well as general safety, on 8/30, 9/1, 9/3, and 9/5/11, by PT and the Director of Nursing.</p> <p>Continued in-servicing with CNAs and nursing staff planned to provide appropriate and safe environment for all residents. All nursing staff has been instructed to report immediately any potentially unsafe condition to Charge Nurses and subsequently to the Director of Nursing.</p> <p>Compliance will be monitored weekly in CQI Committee meetings.</p>		
			F 323	9/14/11	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/26/2011
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NAME OF PROVIDER OR SUPPLIER DOVER MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 112 DOVER DRIVE GEORGETOWN, KY 40324
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F 323

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occurred. She further stated the CNAs weren't doing anything different when caring for Resident #2, just "being careful".

Interview with the Director of Nursing, on 08/26/11 at 1:20 PM, revealed she had been involved in the investigation to determine the cause of the bruise. She confirmed no inservice training had been conducted at the time of the investigation, and the Care Plan had not been updated with specific interventions related to preventing a similar injury from occurring in the future. Continued interview revealed Resident #2 had not yet been evaluated by the Therapy Department for possible modifications in care.

F 323