

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

PRINTED: 04/02/2015  
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  C 03/19/2015
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NAME OF PROVIDER OR SUPPLIER  DOVER MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 112 DOVER DRIVE GEORGETOWN, KY 40324
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F 000 INITIAL COMMENTS

A Recertification Survey was initiated on 03/17/15 and concluded on 03/19/15. Deficiencies were identified and cited at the highest Scope and Severity of a "D". Concurrently, an Abbreviated Survey to investigate #KY00022957 was conducted. #KY00022957 was unsubstantiated.

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

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

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

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

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review and review of Facility Policy it was determined the facility failed to develop a Comprehensive Care

F 000

F 279

RECEIVED  
APR 29 2015  
BY: \_\_\_\_\_

RECEIVED  
APR 28 2015  
BY: \_\_\_\_\_

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Michael Sullivan* TITLE: *Administrator* (X6) DATE: *4/20/15*

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

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F 279	Continued From page 1  Plan for one (1) of sixteen (16) residents. Resident #10 exhibited behaviors of eating non-food and potentially dangerous items. Review of the comprehensive Care Plan revealed no documented evidence of a plan for addressing the resident's behaviors.  The findings include:  Review of the facility's policy, titled "Care Plan Conference Policy", not dated, revealed if the nurse identified concerns which needed to be addressed on the Care Plan, the nurse was to work with the Charge Nurse to address the concerns within 24-48 hours.  Medical record review revealed the facility admitted Resident #10 on 07/15/14 with diagnoses which included Behaviors, Altered Mental Status, and Anxiety. Review of the Brief Interview for Mental Status (BIMS), dated 01/05/15, revealed the facility assessed Resident #10 to have a score of four (4), indicated severe cognitive impairment.  Review of the Nurses Notes, dated 02/24/15, revealed a Certified Nursing Assistant (CNA) removed five (5) Quarters from Resident #10's mouth. Continued review revealed beads were found in the resident's room and were returned to the Activities Department. Further review of the Nurses Notes, dated 03/06/15, revealed Resident #10 was found with lotion bottles near his/her mouth. CNA stopped the resident and wrote a note to tell him/her it was lotion and offered the resident water. Lotions locked in cabinet.  Record Review on 03/17/15 revealed no current Comprehensive Care Plan for Behaviors.	F 279 F 279	The Care Plan for Resident #10 (the affected resident) was revised and updated by MDS Coordinator, LPN, on 3/19/15.  MDS and Care Plans for all residents in the facility were reviewed on 3/20, 3/23, and 3/24/15, by MDS Coordinators and LPN D.C., and no additional deficiencies were noted.  All nurses were in-serviced regarding the MDS Communication Policy and Procedure on 3/24, 3/25, 3/30, and 4/1/15, by the Director of Nursing. In-services included instruction for reporting incidents that involved isolated and unusual occurrences, and how to communicate those to MDS Coordinators. Use of the MDS Communication book and Master Log continues, allowing a double check and verification process.  The MDS Communication book is checked and verified for accuracy daily, Monday through Friday, by the MDS Coordinators.  Compliance will be monitored in the weekly CQI Committee meetings through the QAPI process for a period of 90 days to verify accuracy.  <b>Completed 4/2/15</b>		

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F 279	<p>Continued From page 2</p> <p>Interview with CNA #5, on 03/19/15 at 1:35 PM, revealed Resident #10 exhibited behaviors of trying to eat the paper on the meal trays, and opening the pepper and sugar packets and pouring them into his/her mouth. She stated any concerns or issues that occurred were to be reported to the nurses and other CNAs, and the nurses passed the information along in their reports at shift change. Continued interview revealed the nurse or the Minimum Data Set (MDS) Assessment Coordinator were responsible for making any changes to the Care Plan.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 03/19/15 at 2:15 PM, revealed Resident #10 was known to put non-food items into his/her mouth. She stated coins were found in the resident's mouth a few weeks ago and had to be removed from the resident's room. She further stated the Care Plan should have been updated to include the resident's behaviors.</p> <p>Interview with the MDS Assessment Coordinator, on 03/19/15 at 2:55 PM, revealed how behaviors or any change in resident status should be reported to the MDS nurse as soon as possible. Continued interview revealed she developed new care plans to address identified problems as indicated when she became aware of changing needs. She further stated the nurses can also make changes to the care plans.</p> <p>Interview with Charge Nurse #1, on 03/19/25 at 3:05 PM, revealed if the CNA observed behaviors, they should report to the nurse, who should inform the MDS Coordinator. Charge Nurse #1 stated the comprehensive Care Plan should have been updated to reflect a behavioral</p>	F 279		
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F 279	Continued From page 3 plan of care related to Resident #10's observed behaviors.  Interview with the Director of Nursing (DON), on 03/19/15 at 4:00 PM, revealed observed resident behaviors should be reported to the nurse and the MDS Coordinator for discussion and necessary care planning during the daily stand-up meetings. The DON acknowledged a care plan to address Resident #10's behaviors should have been developed.  Interview with the Administrator, on 03/19/15 at 4:20 PM, revealed he expected perfection. He stated the comprehensive Care Plan should be an accurate reflection of the current condition of the resident.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		

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F 280

Continued From page 4

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Care Plan was revised for two (2) of sixteen (16) sampled residents (Residents #7 and #12).

Resident #12 was admitted on 02/10/15 with a Stage III pressure ulcer on his/her right hip which was treated and care planned with interventions on 02/10/15. Further review revealed the pressure ulcer was healed on 02/23/15 according to the Physician's orders, the Weekly Skin Tracking Assessments, and the skilled daily Nurses Notes; however, the Comprehensive care plan was not revised to reflect the wound had healed.

Resident #7 had a significant change in eating ability documented on the 08/08/14 Minimum Data Set (MDS) Assessment. The Comprehensive Care Plan was not revised to reflect the resident's new status when he/she became able to eat independently.

The findings include:

1. Review of the facility's policy titled "Care Plan Revisions", undated, revealed care plans were to be revised within twenty-four (24) to forty-eight (48) hours of receipt of a Physician's order, and as needed. Continued review revealed Physician orders were to be faxed to the Minimum Data Set

F 280

F 280

The Care Plans for Resident #7 and Resident #12 were corrected on 3/19 by MDS Coordinator, LPN.

All nursing staff were re-educated regarding the procedures for ensuring that all orders are transmitted to MDS Coordinators on 3/24, 3/24, 3/27/ 3/30, and 4/1/15, by Director of Nursing. In-services included instruction for process necessary to communicate to MDS Coordinators, use of the MDS Communication Book and Master Log.

Nurses are responsible for receiving all orders, for entering these orders in the resident charts, and for transmitting the orders to the MDS Coordinators.

A new process has been created to verify receipt of orders is accurate and timely. Administrative Assistant, D. Shuler has been tasked with reconciling hard copies of orders on wings with faxed orders to MDS Coordinators. She will collect and assemble all hard copy orders from nursing wings on a daily basis, Monday through Friday, and compare those to faxed orders received by MDS Coordinators to verify receipt of all orders. Any omission would be discovered at that time.

The hard copies are then to be stapled to the faxed copies and these are kept in

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F 280	Continued From page 5 (MDS) office for follow-up and necessary revisions to the Care Plan by the MDS nurse.  Review of the clinical record revealed Resident #12 was admitted by the facility on 02/10/15 with diagnoses which included Stage III Pressure Ulcer to the right hip.  Review of the Admission MDS Assessment, dated 02/18/15, revealed the facility assessed Resident #12 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), which indicated the resident had no cognitive impairment.  Review of the Physician's Order, dated 02/10/15, revealed Resident #12 was to be turned and repositioned every two (2) hours related to a Stage III pressure ulcer on the right hip, and the ulcer was to be treated as follows: the ulcer was to be cleansed with normal saline, zinc oxide was to be applied to the peri wound area, calcium alginate was to be applied to the wound bed, and the ulcer was to be covered with adhesive foam dressing and changed every three (3) days and as needed. Continued review revealed a Physician's Order, dated 02/23/15, to discontinue the right hip pressure ulcer treatment ordered on 02/10/15 related to the ulcer having healed.  Review of the Weekly Skin Tracking Assessment dated 02/10/15 revealed a Stage III pressure ulcer was present on the right hip at the time of Resident #12's admission to the facility. Review of the Weekly Skin Tracking Assessment dated 02/17/15 revealed the Stage III ulcer remained but was improved. Review of the Weekly Skin Tracking Assessment dated 02/23/15 revealed the Stage III pressure ulcer on the right hip had	F 280 F 280	Continued  a newly created three-ring binder for a period of twelve months of creation. In addition, the duplicate communication form and order is housed in the resident chart permanently.  MDS Coordinators will update SRNA Care Plans as required as orders are received.  Compliance will be monitored by LPN and Administrative Assistant by actual visual inspection and verification twice weekly for a period of 90 days for accuracy. The results of their findings will be submitted to the Director of Nursing on a weekly basis to determine accuracy of procedure.  The deficiencies received in this annual survey were immediately reported to the facility Medical Director. The Medical Director participates in the CQI meetings on a quarterly basis, however, his Nurse Practitioner is physically in the facility one day each week, and she reviews the Communication Books housed on each wing and forwards pertinent information to the Medical Director on a weekly basis. There is an open line of communication to and from the office of the Medical Director, his Nurse Practitioner, and the facility.		

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F 280	<p>Continued From page 6 healed.</p> <p>Review of the Skilled Daily Nurses Notes, dated 02/23/15 at 7:00 AM, revealed the Stage III pressure ulcer on the right hip had healed and the treatment order had been discontinued.</p> <p>Review of the Comprehensive Care Plan, dated 02/10/15, revealed Resident #12 had a Stage III pressure ulcer on the right hip, with the goal being for the wound to show signs of healing and remain free from infection by/through the next review date. Continued review of the Care Plan revealed the last interventions related to the pressure ulcer were made on 02/11/15, and the target (goal) date was 05/19/15. The Comprehensive Care Plan was not revised on or after 02/23/15 to reflect healing of the the Stage III pressure ulcer to the right hip.</p> <p>Interview with the MDS nurse, on 03/19/15 at 12:50 PM, revealed the Comprehensive Care Plans were revised and updated daily. Further interview revealed the MDS nurses received a copy of all Physician's Orders daily, and Resident #12's Care Plan should have been revised on 02/23/15 when the pressure ulcer was healed and treatment was discontinued by the Physician. Continued interview revealed the MDS nurse believed the staff nurses were also responsible for updating care plans as they transcribed Physician orders.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 03/19/15 at 1:15 PM, revealed the MDS nurses were responsible for updating the Comprehensive Care Plans, and the staff nurses were responsible for transcribing Physician orders, faxing the orders to the pharmacy and (he</p>	F 280  F 280	<p><b>Continued</b></p> <p>The Quality Assurance Committee consists of the Administrator, Director of Nursing, All Department heads, and individuals selected to participate in QAPI process in resolution of areas identified in QA process.</p> <p>Findings will be reported to the CQI Committee in weekly meetings for a period of 90 days.</p> <p><b>Completed 4/9/15</b></p>	

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F 280	<p>Continued From page 7</p> <p>MDS office, and placing a copy of the Physician orders in a designated bin for the MDS nurses to pick up daily. She stated sometimes the MDS nurses picked the slips up more than once throughout the day. Further interview revealed the staff nurses were responsible for updating the State Registered Nurse Aide (SRNA) care plans but not the Comprehensive Care plans.</p> <p>Interview with Registered Nurse (RN) #1 and LPN #7, on 03/19/15 at 1:25 PM, revealed the staff nurses were responsible for transcribing Physician orders and updating the SRNA care plans, and the MDS nurses were responsible for updating the Comprehensive Care Plans.</p> <p>Interview with the Director of Nursing (DON), on 03/19/15 at 3:26 PM, revealed it was the MDS nurses' responsibility to update/revise the Comprehensive Care Plans based on Physician orders, and staff nurses were responsible for updating the SRNA care plans. Further interview revealed she would have expected the MDS nurses to revise/resolve Resident #12's Comprehensive Care Plan related to a pressure ulcer on 02/23/15 when the pressure ulcer was healed.</p> <p>2. Review of facility's policy titled "Resident Assessment Instrument (RAI) Minimum Data Set (MDS) Policy", not dated, revealed when there was a change in a resident's status, there should be consideration to change the resident's Care Plan.</p> <p>Medical record review revealed the facility re-admitted Resident #7 on 07/27/14 with Gastrointestinal Esophageal Reflux Disease (GERD) and Dysphagia. Review of the</p>	F 280			

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F 280	Continued From page 8 Significant Change MDS Assessment dated 08/03/14, and the Quarterly MDS Assessment dated 02/01/15, revealed Resident #7 was independent with eating.  Observations on 03/17/15 at 11:20 AM, 12:15 PM, 12:35 PM, and 6:02 PM, revealed Resident #7 was eating independently.  Review of the Comprehensive Care Plan, dated 05/15/14, revealed Resident #7 was totally dependent on staff for eating.  Review of the Certified Nursing Assistant (CNA) Care Plan for 03/17/15 revealed Resident #7 was dependent for meals.  Interview with CNA #3, on 03/19/15 at 1:50 PM, revealed Resident #7 was able to eat independently. CNA #3 stated she did not realize the CNA Care Plan indicated Resident #7 required total assistance with feeding. She further stated it must be a mistake because Resident #7 had no problems feeding his/herself. Continued interview revealed she should have looked at the CNA Care Plan more often, and let the nurse know if there was a mistake.  Interview with LPN #2, on 03/19/15 at 2:00 PM, revealed Resident #7 was able to eat independently after tray set up. She stated the MDS Coordinator was responsible for updating the Care plan.  Interview with the MDS Coordinator, on 03/19/15 at 2:55 PM, revealed she visited residents to verify assessment information. She stated Resident #7's Care Plan should have been revised when the resident became able to eat	F 280			

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F 280	Continued From page 9 independently. She further stated the failure to update the Care Plan was an oversight.  Interview with the DON, on 03/19/15 at 4:00 PM, revealed the CNAs were expected to review the CNA care plans daily. She stated any time there was a significant change in a resident's status, like Resident #7's change in eating ability, the Comprehensive Care Plan should be updated to reflect current status.  Interview with the Administrator, on 03/19/15 at 4:24 PM, revealed it was his expectation for the Comprehensive Care Plans to accurately reflect each resident's current status and treatment needs.	F 280			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431			

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F 431	<p>Continued From page 11</p> <p>recommendations or the provider pharmacy's directions for storage, use, and disposal. Further review of the policy revealed the first person to open a multi-dose vial was to initial and date the vial itself or affix an accessory label to the vial.</p> <p>Review of the facility's policy titled "Guidelines for Discarding Opened Multidose Products", including "Medication Expiration Dating", revised January 2007, revealed tuberculosis skin testing multi-dose vials were to be dated when opened, and expired thirty (30) days after the open date.</p> <p>Observation with Licensed Practical Nurse (LPN) #3, on 03/18/15 at 10:53 AM, revealed a medication refrigerator in the Hall B medication room contained an open tuberculin multi-dose vial. Continued observation revealed the vial was not dated with initials or a date when the vial was opened.</p> <p>Interview with LPN #3, on 03/18/15 at 10:53 AM, revealed the multi-dose vial of tuberculosis testing solution should have been dated and initialed when opened. She stated the medication would expire thirty (30) days after opening, but there was no way to know when the expiration date was without a proper label.</p> <p>Interview with LPN #4, on 03/19/15 at 10:30 AM, revealed any nurse in the facility could use the tuberculosis testing multidose vials as the unit nurses administered tuberculosis testing for the residents, and the Minimum Data Set (MDS) nurse administered tuberculosis testing for the staff. Further interview revealed the tuberculosis testing multi-dose vials should be stored in a locked medication refrigerator, and the vial should be dated and initialed when opened so the thirty</p>	F 431			

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

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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 03/19/2015
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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 431 Continued From page 12  
(30) day expiration date would be known.

Interview with LPN #8, on 03/19/15 at 2:08 PM, revealed tuberculosis testing multi-dose vials should be stored in a locked refrigerator and should be dated upon opening in order to determine the expiration date. She stated she believed the medication expired thirty (30) days after it was opened.

Interview with the Director of Nursing, on 03/19/15 at 3:26 PM, revealed it was her expectation for tuberculin multi-dose vials to be dated upon opening because the vials expired thirty (30) days after the date opened. Further interview revealed all nursing staff were educated on dating the tuberculosis testing multi-dose vials upon opening, and should be aware of the expiration date thirty (30) days later.

Interview with the Administrator, on 03/19/15 at 4:24 PM, revealed his expectation was for tuberculin multi-dose vials to be dated when opened, as stated in the facility's policy, in order to ensure the vial was not used beyond the expiration date.

F 431

F 441 483.65 INFECTION CONTROL, PREVENT SS=D SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program  
The facility must establish an Infection Control Program under which it -

F 441



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F 441	<p>Continued From page 14</p> <p>Review of the facility's policy titled "Hand Washing Policy During Meal Service/Tray Passing", not dated, revealed staff were to follow proper hand washing procedures during meal service and tray passing after handling any contaminated items or after touching trays, carts, food items and residents.</p> <p>1. Observation in the Sunroom dining area, on 03/17/15 at 12:10 PM, revealed SRNA #2 left the dining area in the middle of feeding Unsamped Resident B, proceeded down the hallway, knocked on a resident's door, opened the door and entered the room. Continued observation revealed SRNA #2 returned to the dining area and resumed feeding Unsamped Resident B without washing or sanitizing her hands.</p> <p>Interview with SRNA #2, on 03/17/15 at 2:40 PM, revealed she should have sanitized her hands before returning to feed Resident B. She stated failing to do so could spread infection and make Resident B sick. Continued interview revealed it was her second day working in the facility, and she had been re-educated by the Director Of Nursing about proper hand sanitization between residents.</p> <p>Interview with Licensd Practical Nurse (LPN), #1 on 03/17/15 at 2:46 PM, revealed all now staff members received an orientation guide, which included infection control practices. The LPN stated SRNA #2 should have washed her hands between residents to prevent the spread of germs.</p> <p>2. Observation, on 03/17/15 at 5:50 PM, revealed State Registered Nursing Assistant (SRNA) #1</p>	F 441	<p>New hand sanitizer dispensers were placed in strategic locations in the facility, including corridors, resident rooms, and the dining room on 4/1/15, by the Maintenance Supervisor. New "reminder" signs pertaining to hand-washing were placed in the facility in restrooms, on the nursing stations, and in the employee break-room on 3/27/15, by D.S., Administrative Assistant.</p> <p>A new Hand Hygiene Audit Form was adopted on 3/23/15, and this form has been used to perform competency evaluations on employees daily since 3/23/15. 25% of all nursing staff have been evaluated daily by Charge Nurses on all three shifts since 3/23/15. Results of night and weekend competency testing has been provided to the Director of Nursing on the forms provided.</p> <p>Any employee failing to perform hand-washing properly as determined on the audit form were re-educated immediately in stand-up meetings by the Charge Nurses and by the Director of Nursing. This has been performed daily since 3/23/15. A binder has been created that houses all of the audit forms created through this process.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 15</p> <p>passed supper trays to multiple residents rooms, but did not sanitize or wash her hands between tray passes. Continued observation revealed SRNA #1 assisted a resident to reposition in the wheel chair, and did not wash her hands after she touched the residents clothing. Further observation revealed SRNA #1 proceeded to feed another resident (Unsampled Resident A) without washing or sanitizing her hands.</p> <p>Interview with SRNA #1, on 03/18/15 at 3:40 PM, revealed she assisted with the evening meal tray pass on 03/17/15, and repositioned residents for supper by touching the resident's clothes. She acknowledged she only used the germicidal hand sanitizer once, and did not sanitize or wash her hands after she passed each resident's tray, or after she touched a resident's clothing and before feeding another resident. Continued interview revealed staff were to wash or sanitize their hands between each resident interaction.</p> <p>Interview with Charge Nurse #2, on 03/19/15 at 9:50 AM, revealed staff were to wash or sanitize their hands between each tray pass to prevent any cross-contamination.</p> <p>Interview with The Director of Nursing (DON), on 03/19/15 at 4:15 PM, revealed it was her expectation that all staff practiced safe food handling. She stated staff should never leave a dining service area without washing their hands, and should wash their hands upon returning. She further stated it was an infection control concern if proper handwashing procedures were not followed.</p> <p>Interview with The Administrator, on 03/19/15 at 4:29 PM, revealed he expected all staff to follow</p>	F 441	<p>The Director of Nursing has been in contact with Andrea Flinchum, MPH, BSN, CIC, HAI Prevention Program Manager of The Infectious Disease Branch of the CDC, in Frankfort, KY, on several occasions since 4/21/15, who has been consulted for guidance in creating new programs. The facility is working with Ms. Flinchum on other projects, and she is known to us as a consequence of our involvement with our involvement in those projects.</p> <p>The results of the training, competency evaluations and re-training are submitted to the Director of Nursing and Administrator and are evaluated by same in the CQI, QAPI weekly meetings held each Monday at 12:00 P.M.</p> <p>Competency evaluations and re-training will be continued for a period of 45 days with 25% of staff being evaluated.</p>		
		F 441	<b>Completed 4/22/15</b>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 16 proper infection control procedures to prevent the spread of illness or infection.	F 441		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

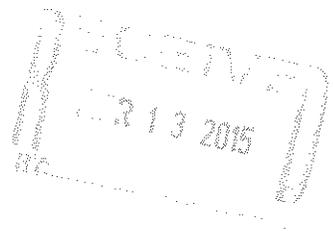
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185295	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING	(X3) DATE SURVEY COMPLETED  03/18/2015
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NAME OF PROVIDER OR SUPPLIER  DOVER MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 112 DOVER DRIVE GEORGETOWN, KY 40324
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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  BUILDING: 01  PLAN APPROVAL: 06/15/77  SURVEY UNDER: NFPA 101 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One (1) story Type V (111)  SMOKE COMPARTMENTS: Six (6) smoke compartments  FIRE ALARM: Complete fire alarm system with smoke and heat detectors  SPRINKLER SYSTEM: Complete (wet) sprinkler system  GENERATOR: One (1) Type II natural gas generator.  A standard Life Safety Code survey was conducted on 03/18/15. Dover Manor was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for eighty-five (85) beds with a census of seventy-nine (79) on the day of the survey.  The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michael Golden, Administrator</i>	DATE 4/2/15
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 60 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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	Continued From page 1	K 000		
K 018 SS-D	<p>Deficiencies were cited with the highest deficiency identified at "D" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors would resist the passage of smoke, according to National Fire Protection Association (NFPA) Standards. The deficiency had the potential to affect one (2) of six (6) smoke compartments, six (6) residents, staff and visitors.</p>	K 018		

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

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K 018	<p>Continued From page 2</p> <p>The findings included:</p> <p>Observation on 03/18/15 at 11:00 AM, with the Maintenance Director, reveled the door of Resident Room #20 had a gap greater than 1/8 inch between the door face and the door jamb. Interview, with the Maintenance Director, revealed door are checked for any problems but he had not identified the door as having a gap greater than 1/8 inch.</p> <p>Observation on 03/18/15 at 11:03 AM, with the Maintenance Director, reveled the door of Resident Room #18 had a gap greater than 1/8 inch between the door face and the door jamb. Interview, with the Maintenance Director, revealed door are checked for any problems but he had not identified the door as having a gap greater than 1/8 inch.</p> <p>Observation on 03/18/15 at 11:57 AM, with the Maintenance Director, reveled the door of Resident Room #34 had a gap greater than 1/8 inch between the door face and the door jamb. Interview, with the Maintenance Director, revealed door are checked for any problems but he had not identified the door as having a gap greater than 1/8 inch.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-banded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the</p>	K 018	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 018	Continued From page 3 passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.  Centers for Medicare and Medicaid Survey and Certification Letter: 07-18	K 018  <b>K018</b>	The defective doors were found to have warped over time. All doors in the facility have been checked and have been found to be within specifications.  Solid wood doors with a fire rating of 20 minutes were ordered from Cox Interiors, Campbellsville, and were received on 4/9/15.  New doors are currently being stained, coated with polyurethane, and prepared for installation. Doors will be installed prior to 5/1/15. <b>Completed 5/2/15</b>	