

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  12/13/2024
NAME OF PROVIDER OR SUPPLIER  Dover Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  112 Dover Drive Georgetown, KY 40324	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44000</p> <p>Based on observation, interview, review of the package insert for latanoprost ophthalmic solution, and review of the facility's policy, the facility failed to ensure that medications were secure and inaccessible to unauthorized staff and residents and were stored properly for one of four medication carts, the B Wing Upper medication cart.</p> <p>1. Observation on [DATE] of the B Wing Upper medication cart revealed it was unlocked and unattended. The staff member who was working with the cart was not in the area.</p> <p>2. Observation on [DATE] of the B Wing Upper medication cart revealed it contained an unopened box of latanoprost ophthalmic solution 0.005% (used to treat glaucoma) belonging to Resident (R) 3, which was labeled refrigerate. There was also an opened box of latanoprost 0.005% belonging to R3, and neither the box nor bottle were dated.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Medication Storage in the Facility, dated [DATE], revealed medications and biologicals were stored safely, securely, and properly, following manufacturer's recommendations. Per the policy, the medication supply was accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications, and medication carts were locked when not attended by persons with authorized access. The policy stated medications requiring refrigeration were kept in a refrigerator at temperatures between 36 degrees Fahrenheit (F) to 46 degrees F. Per the policy, drugs dispensed in the manufacturer's original container would be labeled with the manufacturer's expiration date.</p> <p>1. Observation on [DATE] at 1:40 PM revealed the B Wing Upper medication cart was unlocked and unattended. Further observation revealed there was no staff in the area.</p> <p>In an interview with Registered Nurse (RN) 2 on [DATE] at 1:45 PM, she stated she was assigned to the B Wing Upper medication cart and was unaware she had left it unlocked when she went into a resident's room. RN2 stated it was expected that the medication cart be locked at all times when not preparing medications and when unattended. RN2 stated it was important to keep all medication carts secured because any resident, visitor, or staff member could potentially open the cart and take medications.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the Assistant Director of Nursing (ADON) on [DATE] at 2:37 PM, she stated it was the expectation for all licensed staff assigned to medication carts to keep them locked at all times when not actively preparing medications so that unauthorized persons could not access them.</p> <p>In an interview with the Director of Nursing (DON) on [DATE] at 3:00 PM, she stated it was the expectation for all licensed staff assigned to medication carts to keep them locked at all times when not actively preparing medications so that unauthorized persons could not access the carts. The DON stated if a cart was found to be unlocked and unattended it would be immediately secured, the assigned employee would be located and informed, an immediate audit of the medication cart would be performed, and appropriate corrective action would be taken.</p> <p>In an interview with the Administrator on [DATE] at 3:58 PM, she stated the expectation for medication storage and securement was that all licensed staff was to follow the facility's policy.</p> <p>2. Review of the package insert information for latanoprost ophthalmic solution 0.005% at <a href="https://www.accessdata.fda.gov">https://www.accessdata.fda.gov</a>, revealed to store unopened bottles under refrigeration at 36 degrees to 46 degrees F. Further, once a bottle was opened, it could be stored at room temperature for six weeks.</p> <p>Observation on [DATE] at 2:49 PM of the B Wing Upper medication cart revealed R3's unopened box of latanoprost 0.005% ophthalmic solution labeled refrigerate, and R3's opened box where neither the box nor the bottle were dated.</p> <p>During interview with RN3 at the time of the observation, she stated she would not have used the unopened box of latanoprost and would have requested a refill that the facility would pay for. She also stated she did not open the bottle of latanoprost, so she did not know when it was opened. She stated she saw on the label the bottle was dispensed [DATE], so she knew it was not expired.</p> <p>During interview with Licensed Practical Nurse (LPN) 5, who was also the Unit Manager of the B Wing, on [DATE] at 10:40 AM, she stated she always dated medications when she opened them. She stated the medications might not be effective if they were expired. She also stated staff went through the medication carts regularly and disposed of any undated or expired medication. She stated the unrefrigerated and undated latanoprost were just overlooked.</p> <p>During interview with the Pharmacist on [DATE] at 2:16 PM, she stated the shelf life of latanoprost after it was removed from the refrigerator was 42 days (six weeks). She stated if latanoprost was used after 42 days the medication might not be effective.</p> <p>During interview with the DON on [DATE] at 11:09 AM, she stated when nursing staff received medication from pharmacy, they always refrigerated medications if needed. She stated the unrefrigerated latanoprost was an oversight. She stated the medication might not be effective if it were used after the expiration date, and the resident could potentially be harmed.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview with the Administrator on [DATE] at 11:14 AM, she stated she relied on the management staff to make sure medications were stored properly. She stated she was not notified of unrefrigerated medications in the medication cart. She further stated she was going to take the issue to the Quality Assurance Performance Improvement (QAPI) meeting, and they would discuss the best way to assure medications were stored appropriately. She stated the unrefrigerated and undated bottle of latanoprost would be disposed of and two new bottles would be ordered for R3 and paid for by the facility.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>32635</p> <p>Based on observation, interview, record review, and review of the facility's policy, the facility failed to store food safely in two of two nourishment refrigerators as determined by observations on 12/09/2024, the nourishment refrigerators on the A Unit and the B Unit.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Food Brought in from Outside Sources and Personal Food Storage, dated 2019, revealed foods from outside sources that required refrigeration or freezing would be labeled with the resident's name and date and stored in the refrigerator/freezer. Per the policy, staff would monitor and document the unit refrigerator temperatures.</p> <p>1. Observation of the B Unit nourishment refrigerator on 12/09/2024 at 1:42 PM revealed an opened container of applesauce and an opened pudding cup in the door of the refrigerator. Further observation revealed grapes and a container of Chinese food was not dated and not labeled. Also observed in the freezer door were two boxes of lemon glycerin swab sticks, one one-half cup of ice cream, and 36 popsicles that were not dated or labeled.</p> <p>Review of the facility's form Temperature Monitoring Log, dated 12/2024 and for the B Unit nourishment refrigerator, revealed there was no documentation of temperatures for 12/07/2024, 12/08/2024, and 12/09/2024.</p> <p>2. Observation of the A Unit nourishment refrigerator on 12/09/2024 at 2:58 PM revealed it contained half a box of lemon glycerin swab sticks in the freezer.</p> <p>In an interview with the Dietary Manager on 12/12/2024 at 2:20 PM, she stated once weekly she removed food from the resident refrigerators that were not dated and had no resident name. She stated the nursing staff was responsible for recording the refrigerator and freezer temperatures. She stated if the temperatures were not recorded, the refrigerator and freezer might not be working, and the food could spoil. She stated the mouth swabs were not kept in the nourishment refrigerators, and the opened and not labeled or dated applesauce and pudding must be thrown away.</p> <p>In an interview with Licensed Practical Nurse (LPN) 1, A Unit Manager, and LPN5, B Unit Manager, on 12/12/2024 at 2:49 PM, both stated the nurses on the night shift were responsible for recording the nourishment refrigerator and freezer temperatures. Both stated if the temperatures were not recorded, the refrigerator and freezer could have abnormal temperatures, and food could thaw, refreeze, and spoil. Both stated there should not be any unidentified open containers kept in the nourishment refrigerators or any items from the medication cart stored with the residents' food.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>In an interview with the Director of Nursing on 12/12/2024 at 3:04 PM, she stated the night shift nurses recorded the nourishment refrigerator and freezer temperatures because if the temperatures were not recorded, the food could be spoiled. She stated the lemon glycerin swabs were kept in the freezer for Hospice residents because they liked the swabs cold, and there was no freezer in medication storage to store the glycerin swabs. She stated the glycerin swabs were not kept with food, and the applesauce and the pudding must be labeled and dated. She stated no opened food should be left in the refrigerator without a date and identification for a specific resident. She stated the applesauce and pudding should be thrown away because bacteria grew in food left open.</p> <p>In an interview with the Administrator on 12/12/2024 at 3:17 PM, she stated temperatures should be recorded for the refrigerator and freezer because if they were not in the correct range, the food could spoil. She stated the opened containers of applesauce and pudding should be thrown out.</p>