STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185295	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dover Nursing & Rehabilitation Center	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview, record review, and review of the Resident Assessment Instrument (RAI), the facility failed to ensure an assessment accurately reflected the resident's status for 1 of 18 sampled residents, Resident (R) 52.Review of the admission Minimum Data Set (MDS) assessment, dated 08/18/2025, and review of the quarterly MDS assessment, dated 02/14/2026, revealed the facility failed to identify R52 had an indwelling catheter. The findings include:Review of the Long-Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0, dated 10/2025, revealed the intent of the items in this section is to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel training programs, and bowel patterns. Each resident who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments and/or devices) and services to achieve or maintain as normal elimination function as possible. An indwelling catheter is maintained within the bladder for the purpose of continuous drainage of urine.Observation of R52 on 03/18/2026 at 9:31 AM, revealed the resident was dressed, sitting in his wheelchair with a catheter bag below, enclosed in a dignity bag. Review of R52's admission Record revealed the facility admitted the resident on 08/07/2025 with diagnoses to include dementia, anxiety, and urinary retention.Review of R52's admission MDS with an Assessment Reference Date (ARD) of 08/18/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of nine out of 15, indicating the resident had moderate cognitive impairment. Further review revealed no documentation of the indwelling catheter.Review of R52's Physician Orders, dated 08/18/2025, revealed an order of an indwelling catheter size 16 French/10 cubic centimeters (cc). Review of R52's quarterly MDS with an ARD of 02/14/2026, revealed no documentation of the indwelling catheter.Review of R52's Treatment Assessment Record (TAR), dated 08/18/2025, 09/01/2025, 10/01/2025, 11/01/2025, 12/01/2025, 01/01/2026, 02/01/2026, and 03/01/2026, revealed the indwelling catheter 16 French/10 cc every shift for indwelling catheter care related to retention of urine.Review of R52's Care Plan, dated 09/23/2025, revealed the focus of urinary catheterization that specified use of a 16 French Foley catheter with a 10 milliliter (ml) balloon related to obstructive uropathy. Further review revealed the goal was the resident will be/remain free from catheter-related trauma through the review date. For the intervention catheter, position the catheter bag and tubing below the level of the bladder and away from entrance room door.In an interview with the Registered Nurse (RN) MDS on 03/19/2026 at 10:33 AM, she stated if R52 had an indwelling catheter upon admission, there should be documentation on the admission MDS and the quarterly MDS. She stated the MDS assessments should have had the catheter use indicated and it was currently inaccurate. In an interview with the Director of Nursing (DON) 03/19/2026 at 10:50 AM, she stated her expectation was all information about each resident should be captured in the MDS assessments in order to provide the appropriate care for the resident.In an interview with the Administrator on 03/19/2026 at 10:50 AM, she stated she expected the MDS assessments to be accurate and the indwelling catheter should have been captured on R52's MDS assessments.

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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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure an ongoing program to support residents in their choice of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 1 of 18 sampled residents, Resident (R) 70. The findings include:Review of the facility's policy titled, Activity Program, effective 08/04/2024, revealed the facility will provide an on-going activities program to support residents in their choice of activities and to meet the interests of and support the physical, mental, and psychosocial wellbeing of each resident. Review of the Long-Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0, dated 10/2025, revealed the overall care plan should be oriented towards: 1. Assisting the resident in achieving their goals; and 2. Individualized interventions that honor the resident's preferences. Review of R70's admission Record revealed the facility admitted R70 on 07/14/2024 with diagnoses to include Parkinson's disease, polyneuropathy (breakdown of the peripheral nerves), and speech and language deficits.Review of R70's admission Minimum Data Set [MDS] with an Assessment Reference Date (ARD) of 07/18/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 13 out of 15, which indicated R70 was cognitively intact.Review of R70's Care Plan, dated 07/14/2024, revealed under activities to provide an activity calendar. Further review revealed to provide assistance as needed getting to and from activities. Additionally, there was no activity listed regarding reading.Review of R70's Activity Log revealed: Reading Activity (group) from 01/01/2026 to 01/31/2026 was not checked; Activity Reading To/Talking Books for 02/01/2026 to 02/28/2026 was not checked; Activity Reading To/Talking Books for 03/01/2026 to 03/17/2026 was not checked.Observation on 03/17/2026 at 10:27 AM revealed R70 lying in bed and the television remote was lying on the bedside table within his reach.During immediate interview with R70 at the time of the observation he stated he was having trouble with the remote for the television. He stated the remote did not work and he stated he used to have books about horses.In an interview with Licensed Practical Nurse (LPN) 1 on 03/17/2026 at 2:15 PM, she stated she did not know if R70 had any books. She stated she would check with activities and see if they could get any books. She further stated R70 used to be a horse jockey.Observation on 03/18/2026 at 1:56 PM revealed R70 lying in bed with the television remote in his hands.During immediate interview with R70, he stated he liked to look at books. He further stated he had told staff he wanted books, and he had not received books. He also stated the activity sheet said today was library day and they did not take him to the library, but he would have gone to the library if staff had taken him. The SA Surveyor observed the activity sheet on R70's bedside table and library was listed.In an interview with State Registered Nurse Aide (SRNA) 2 on 03/18/2026 at 2:37 PM, she stated she did not know R70 liked to read or that he wanted to go to the library. In an interview with Activities Assistant (AA) 1 on 03/18/2026 at 3:25 PM, she stated the book cart goes around to every resident for the opportunity to select books. She could not verify the cart visited R70 on that date. She further stated she was not aware of R70's interest in reading.In an interview with the Activities Director on 03/18/2026 at 3:15 PM, she stated R70 was not visited on that date during the library time scheduled on the activities schedule. She stated she was unaware R70 liked books.In an interview with the Director of Nursing (DON) on 03/19/2026 at 11:02 AM, she stated the Activities Director oversaw the activities. She was unaware that R70 did not get to go to the library activity, and it was her expectation that the SRNAs would take the residents to the activity.In an interview with the Administrator on 03/19/2026 at 11:13 AM, she stated she expected staff to listen to each resident and provide activities specific for each resident. She further stated she was unaware there was an issue with activities for R70 and if she was given the information, she would have addressed the issue.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure that each resident who needed respiratory care was provided with such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 18 sampled residents, Resident (R) 2.The findings include:In an interview with the Administrator on 03/19/2026 at 10:42 AM, she stated the facility did not have a policy related to oxygen administration for residents.Review of R2's Face Sheet revealed the facility admitted the resident on 11/26/2025 with diagnoses to include acute respiratory failure with hypercapnia, other chronic osteomyelitis right ankle and foot, and type 2 diabetes mellitus with other diabetic ophthalmic complications.Review of R2's quarterly Minimum Data Set [MDS] with an Assessment Reference Date (ARD) of 01/13/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 14 out of 15, indicating the resident was cognitively intact.Review of R2's Physician Orders, dated 01/09/2026, revealed the resident was ordered oxygen at two liters per minute (LPM) via nasal cannula.Observation on 03/17/2026 at 11:10 AM revealed R2 was adjusting her oxygen concentrator to 3.5 LPM without an authorized facility staff member present.Observation on 03/17/2026 at 3:12 PM revealed R2's oxygen concentrator was controlled at 3.5 LPM.Observation on 03/18/2026 at 9:03 AM revealed R2's oxygen concentrator was controlled at 2.5 LPM.Observation on 03/18/2026 at 2:58 PM revealed R2's oxygen concentrator was controlled at 2.5 LPM.Observation on 03/18/2026 at 4:22 PM revealed no authorized facility staff member monitoring the concentration level of R2's oxygen liters.Observation on 03/19/2026 at 8:21 AM revealed R2's oxygen concentrator was controlled at 1.5 LPM.Observation on 03/19/2026 at 10:43 AM revealed R2's oxygen concentrator was controlled at 1.5 LPM.Review of R2's Care Plan, revised 11/26/2025, revealed oxygen therapy related to ineffective gas exchange, respiratory illness, chronic obstructive pulmonary diseases (COPD), unspecified, obstructive sleep apnea (adult (pediatric), and acute respiratory failure with hyper acapnia. Further review revealed no documented interventions to monitor the oxygen flow levels or to educate the resident about self-adjusting the flow levels.In an interview with Licensed Practical Nurse (LPN) 3, who was assigned to R2, on 03/18/2026 at 4:25 PM, she stated R2's oxygen order was for 3 LPM, further stating she would need to look at R2's care plan to verify. She stated she reviews residents' care plans daily before starting her shift. She stated she had not made any monitoring attempts to observe R2's oxygen concentrator and the LPM setting on that date.In an interview with the Advanced Practice Registered Nurse (APRN) on 03/19/2026 at 10:42 AM, she stated that every time she had observed the oxygen concentrator, it had been on the wrong liters/minutes due to R2 and her roommate making attempts to adjust the concentrator without medical consent or authorized from a facility staff member. She stated a resident with a diagnosis of COPD, whose oxygen level was increased, could cause their respiratory drive to decrease. She further stated that it could cause the resident to stop breathing as needed and could cause the resident to go into respiratory distress.In an interview with the Director of Nursing (DON) on 03/19/2026 at 11:13 AM, she stated she was unaware of R2 not receiving the correct oxygen LPM. She stated with the resident having a diagnosis of COPD, receiving too much oxygen could cause harm to the resident.In an interview with the Administrator on 03/19/2026 at 11:42 AM, she stated she was not informed R2 was adjusting her oxygen concentrator. She stated the resident could be harmed by receiving too much oxygen. She further stated her expectation was for all facility staff members to follow the residents' care plan and physician's orders. She stated if R2 was adjusting her own oxygen concentrator levels, there should be care plan interventions for resident education and staff monitoring.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and review of the facility's documents, the facility failed to ensure nurse aides received a performance review at least once every 12 months for 1 of 4 employee files reviewed, State Registered Nurse Aide (SRNA) 6.The findings include:Review of the facility's policies revealed no documentation of a policy addressing staff performance evaluations.Review of SRNA6's employee file revealed the facility hired the employee on 06/04/2024; however, further review revealed no documentation of a performance evaluation completed within 12 months of the hire date.In an interview with SRNA6 on 03/18/2026 at 5:38 PM, she stated she thinks she had a performance evaluation in August of 2025, however, no documentation of a completed performance evaluation was available upon request.In an interview with the Administrator on 03/18/2026 at 2:50 PM, she stated she was unable to locate a performance evaluation or training records for SRNA6. She stated it could be misfiled, but was unable to produce any documentation.In further interview with the Administrator on 03/19/2026 at 9:12 AM, she stated I can't imagine I would have not completed a performance evaluation on her. However, she was unable to locate or provide documentation of a performance evaluation completed within 12 months of SRNA6's date of hire.