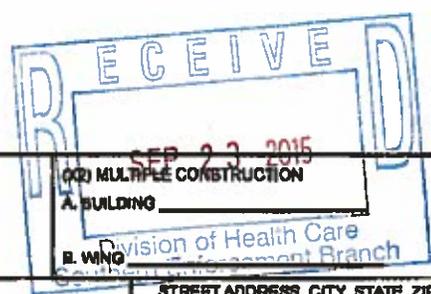


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2015  
 FORM APPROVED  
 OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186222	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ Division of Health Care Enforcement Branch	(X3) DATE SURVEY COMPLETED  08/26/2015
NAME OF PROVIDER OR SUPPLIER  GOOD SHEPHERD COMMUNITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 40 PHILLIPS BRANCH ROAD PHELPS, KY 41663	

(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	F 000		
F 225 SS=D	<p>An abbreviated standard survey (KY23732) was initiated and concluded on 08/25/15. The complaint was substantiated with deficient practice identified at "D" level.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)                      INVESTIGATE/REPORT                      ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance</p>	F 225	<p>Good Shepherd Community Nursing Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The facility reserves the right to contest the survey findings through informal dispute resolution formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility affirms its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p> <p>The allegation of abuse in regards to bruising of unknown origin for Resident #1 was reported to a nurse on day shift. LPN #2 failed to document and notify Administrator immediately. LPN #1 did document and notify Administration.</p> <p>Resident #1 safety was ensured and Resident #1 was assessed by LPN #1 who notified Physician and received orders to send Resident #1 to the hospital. Resident #1 responsible party declined to send her to the hospital. However on 8/12/15 Resident #1 was sent to hospital due to swelling and bruising.</p> <p>All residents with BIMS score &lt;8 were assessed by charge nurses and all residents with BIMS score &gt;8 were interviewed by DON &amp; SSD with no signs/symptoms of abuse noted or reported. An audit of all personnel records was completed by HR Director on 9/14/2015 and results were reviewed by the</p>	9/18/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessie A. Stone TITLE: Belmont Director (X6) DATE: 9-18-15

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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NAME OF PROVIDER OR SUPPLIER  GOOD SHEPHERD COMMUNITY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 60 PHILLIPS BRANCH ROAD PHELPS, KY 41663	
(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 225	<p>Continued From page 1</p> <p>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of the facility policies and procedures it was determined the facility failed to ensure an injury of unknown source was reported immediately to the Administrator as required. An injury of unknown origin/bruising was reported to a nurse on 08/11/15 during the day shift (8:00 AM to 2:30 PM). Review of the resident record revealed no evidence that the nurse documented the bruising or filled out an incident report as required by the facility policy. Further review revealed no evidence the Administrator was immediately notified of the injury of unknown origin. Resident #1's family discovered the injury and reported the injury to evening shift staff on 08/11/15 (2:00 PM to 10:00 PM) who documented the injury and made required notifications.</p> <p>The findings include:</p> <p>A review of the facility policy titled "Abuse Prevention," undated, revealed it was the employee's duty and obligation to report abuse to the administrator immediately. Further review of the policy revealed the facility would utilize incident reports to identify abuse or suspected abuse. According to the policy titled "Investigating Unexplained Injuries," undated, an investigation of all unexplained injuries including bruises and injuries of unknown sources would be</p>	F 225	<p>Administrator on 9/14/2015 with no findings of deficient practice noted. All Incident Reports for the past 30 days were reviewed by the Administrator on 9/14/2015 for any possible allegations not reported and none were identified.</p> <p>Facility department managers to include Administrator, DON, Clinical Supervisor, SDC, MDS, SSD, HR, Chaplain, Maintenance Director and other facility staff will be required to attend a Mandatory Meeting on 9/15/2015 by Ombudsman for training/education on Abuse Policy and Procedure to include reporting requirements. Facility staff were educated/trained by the Executive Director on the Abuse Policy and Procedure to include appropriately reporting to regulatory agencies by 9/15/2015 the DON/Clinical Supervisor/QA Director will audit all Incident Reports daily x 4 weeks to ensure all allegations are reported to the appropriate regulatory agencies. Administrator/DON/QA will audit all grievances daily x 4 weeks to ensure all allegations are reported to appropriate regulatory agencies. Findings of the above stated audits will be reported during monthly QA meeting for review and any recommendations, compliance, needed revisions and/or any needed ongoing education/training.</p> <p>10 Residents with BIMS score &gt; 8 will be interviewed by SSD to ensure no abuse has occurred and not been reported. These interviews will be conducted weekly x 4 weeks then monthly x 2 months.</p> <p>10 Residents with BIMS score &lt; 8 will have Skin Assessments performed to ensure no abuse has occurred and not been reported. These Assessments will be performed weekly x 4 weeks then monthly x 2 months. Results of these interviews and Skin Assessments will be reported during monthly QA meeting to determine the need for ongoing monitoring.</p>	

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NAME OF PROVIDER OR SUPPLIER  GOOD SHEPHERD COMMUNITY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 80 PHILLIPS BRANCH ROAD PHELPS, KY 41663		
(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 225	<p>Continued From page 2</p> <p>conducted by an individual appointed by the administrator to ensure the safety of residents had not been jeopardized. Further review of the policy revealed if a resident was observed with unexplained injuries of unknown source, including bruising, the Nurse Supervisor was required to complete an incident report and to document the information in the resident's clinical record.</p> <p>Observation of Resident #1 conducted on 08/25/15 at 1:25 PM revealed the resident was observed to have old fading bruising to the right upper arm and multiple bruises to both forearms.</p> <p>An interview conducted with State Registered Nurse Aide (SRNA) #4 on 08/25/15 at 5:10 PM revealed the SRNA was assigned to care for Resident #1 on 08/11/15 during the day shift and was checking and changing the resident with SRNA #5 after lunch (exact time not known) and had noticed bruising to the resident's upper arm and armpit area. According to SRNA #4, the area was reported to Licensed Practical Nurse (LPN) #2.</p> <p>An interview conducted with LPN #2 on 08/25/15 at 5:56 PM revealed SRNA #4 had reported to LPN #2 that Resident #1 had a bruise to the upper arm. According to LPN #2, she went and checked the resident and thought the resident had cellulitis due to a previous history of cellulitis. Further interview revealed LPN #2 did not document the bruising in the medical record, complete an incident report, or notify the Administrator of the injury. According to LPN #2, she was busy and forgot to document the bruising, but notified the oncoming nurse (LPN #1) of the bruise on Resident #1.</p>	F 225			

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NAME OF PROVIDER OR SUPPLIER  GOOD SHEPHERD COMMUNITY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 60 PHILLIPS BRANCH ROAD PHELPS, KY 41663		
(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 225	<p>Continued From page 3</p> <p>Interview with LPN #1 conducted on 08/25/15 at 5:30 PM revealed she was informed by Resident #1's family of a bruise on the right upper arm. LPN #1 stated she assessed the bruising, completed an incident report, and notified the physician and family of the bruise.</p> <p>A review of the medical record for Resident #1 revealed the resident was admitted to the facility on 01/24/15 with diagnoses that included Dementia with Behavior Disturbance, Joint Contractures, and Pressure Ulcer to the Coccyx. Further review of the record revealed on 08/11/15 at 9:30 PM Resident #1's family reported Resident #1 had a bruise and swelling to the right upper arm and chest wall which was not there when the family member visited the resident two days earlier. The resident's physician was contacted with orders to send the resident to the hospital for evaluation and treatment. According to the record, the resident's Responsible Party did not want the resident transferred to the hospital. However, on 08/12/15 at 3:55 PM, the swelling and bruising to Resident #1's right upper arm and chest wall became worse and the resident was transferred to the hospital.</p> <p>A review of the hospital records, including pictures, and the admission history and physical for Resident #1 revealed the resident had extensive bruising to the right shoulder, right upper extremity, and the right side of the chest greater than 15 centimeters in length.</p> <p>An interview with the Administrator on 08/25/15 at 7:30 PM revealed he was made aware of the bruising from an incident report on 08/11/15 by the Director of Nursing but was not aware that LPN #2 had not reported the bruise or not</p>	F 225			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186222	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/25/2015
NAME OF PROVIDER OR SUPPLIER  GOOD SHEPHERD COMMUNITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 60 PHILLIPS BRANCH ROAD PHELPS, KY 41663	

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F 225	Continued From page 4 documented when the nurse was made aware of the bruising by SRNA #4. Further interview revealed the resident was transferred to the hospital on 08/12/15 because the bruising was worse. According to the Administrator, the facility thought the cause of the bruising was related to the use of a lift sling and the facility had ordered a larger sling for the resident to use. The Administrator stated the family has requested that the resident only be gotten up from the bed on shower days instead of every day.	F 225		