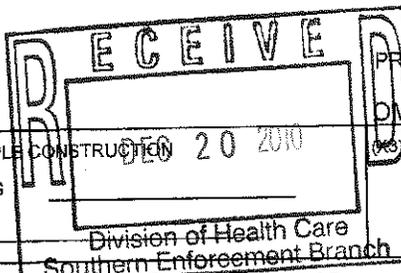


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 12/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185222	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2010
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NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD COMMUNITY NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 60 PHILLIPS BRANCH ROAD, PO BOX 424 PHELPS, KY 41553
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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	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on November 16-18, 2010. Deficient practice was identified at "D" level.</p>	F 000	<p>The two medications that were discovered without dates and initials have been discarded.</p>	12/8/10
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>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.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 431	<p>An in-service was held on 12/8/10 with nursing staff to reinforce our policy for dating and initialing multidose medications when opened. A copy of our policy was given to each nurse and CMA. Our expectations for compliance were discussed with the House Supervisors.</p> <p>A list of medications is generated on a daily basis by Three Forks Apothecary for medications that are delivered to Good Shepherd. The list is maintained in a three ring binder. The House Supervisor will review that list each day to determine if any multidose medications have been delivered to the facility. She/he will then inspect that medication to ascertain if the unit has been opened. If the unit has been opened, she/he will look for a date and initials. If the unit has not been opened, it will be highlighted on the list and continuously reviewed on a daily basis until it is opened to insure the date and the initials are placed on the multidose units when opened.</p> <p>The QA Coordinator/DON/ADON will randomly check multidose units to ascertain compliance is maintained.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/14/10
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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 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 431	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to label, date, and store all drugs and biologicals in accordance with currently accepted professional principles. The facility had one (1) bottle of Megace Extended Strength (ES) and one (1) bottle of GI Cocktail Tea opened and available for use with no dates on the bottles indicating when the bottles were opened and in the cart available for use. The findings include: Observation of the facility's medication room on the AB Unit of the facility on November 18, 2010, at 10:15 a.m., revealed one bottle of Megace Extended Strength (ES) and one bottle of G I Cocktail Tea opened and available for use, however, the bottles did not contain a date indicating when the bottles were opened. An interview conducted with the Director of Nursing (DON) for the facility on November 18, 2010, at 2:38 p.m., revealed the nurse who opened and administered the medication was responsible for dating the medication bottle. According to the DON, the Unit Manager (UM) was responsible for checking to assure all opened medications had been dated indicating the date the medication was opened. A review of the facility policy titled Administrating Medication (no date) revealed staff was required to record the date opened on the medication container.	F 431		

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F 465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The lavatories in the resident women's bathrooms on the AB Unit and the CD Unit were loose from the wall and moveable. Several residents' entrance door corners were splintered and sharp (resident rooms 201, 206, 208, 209, 213, 214, 300, and 314).</p> <p>The findings include:</p> <p>Observation of the facility during the environmental tour performed on November 16, 2010, at 1:20 p.m., revealed the following items were in need of maintenance/repair:</p> <ul style="list-style-type: none"> -Lavatories in the women's bathroom on the AB Unit and the CD Unit were loose from the wall and not firmly affixed. -Entrance doors to resident rooms 201, 206, 208, 209, 213, 214, 300, and 314 were splintered with sharp edges. <p>An interview conducted on November 18, 2010, at 2:25 p.m., with the Maintenance Supervisor (MS) revealed it was the responsibility of all staff</p>	F 465	<p>The lavatories in the shower rooms on A-B Unit and C-D Unit have been firmly affixed to the walls. Metal caps which cover the rough and splintered edges of the doors have been installed on the entrance doors to resident rooms 201, 206, 208, 209, 213, 214, 300, and 314.</p> <p>Department supervisors will continue to perform monthly building QA checks to identify repairs that are needed to the building. A copy of the inspection will be provided to the MS and ED for follow-up.</p> <p>The ED will meet with the MS on a monthly basis to prioritize QA check lists and assign a date for remedy for each needed repair. If a contractor is needed for the repair, the MS will contact the appropriate contractor and schedule the repair.</p> <p>Prior to the monthly QA meeting, the ED will inspect the repairs made to building as a result of the QA checks performed by the Department Supervisors. Results of the inspection by the ED will be discussed in the monthly QA meeting. Projects that have not been completed, will be listed in the minutes of the QA meeting and a deadline established for completion to insure a safe, functional, sanitary, and comfortable environment for the residents, staff, and the public.</p>	12/31/10	

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F 465	Continued From page 3 and department managers to report any items in need of repair to the maintenance staff. The MS stated he/she was aware of the sharp splintered resident door corners. According to the MS, the caps had been purchased to cover the splintered door corners and the MS was in the process of repairing the doors. The MS further stated repairing the splintered corner of the residents' doors was being done as the Maintenance Department found the time to do the repairs. The MS further revealed he/she was aware of the loose lavatories in the women's bathrooms on the AB and CD Units. The MS stated to repair the loose lavatories would require cutting through the bathroom wall from the hallway and the MS had just not made time to do the repairs.	F 465			

**Good Shepherd Community Nursing Center
Shower Room Quality Assurance Check**

Men's ()
 Women's ()
 A/B Wing ()
 C/D Wing ()

Date: _____
 Signature: _____

Area	Comment/Explanation
Are there paper towels in dispenser?	
Is the mirror clean and in good repair?	
Any problems with the lavatory?	
Record temperature of the water in lavatory.	
Is the water pressure good?	
Is there soap in the dispenser?	
Is the light working above the lavatory?	
Is the exhaust fan working properly?	
Is the heater working properly?	
Is the heater in good repair?	
Are there privacy curtains up at shower/tub (1)?	
Are there privacy curtains up at shower/tub (2)?	
Are there privacy curtains up at shower/tub (3)?	
Are there privacy curtains up at shower/tub (4)?	
Are there privacy curtains up at dressing area?	
Are all curtains clean and in good repair?	
Is the water pressure adequate at shower/tub (1)?	
Is the water pressure adequate at shower/tub (2)?	
Is the water pressure adequate at shower/tub (3)?	
Is the water pressure adequate at shower/tub (4)?	
Record the temperature of the water in stall (1).	
Record the temperature of the water in stall (2).	
Record the temperature of the water in stall (3).	

Area	Comment/Explanation
Record the temperature of the water in stall (4).	
Is there a soap dispenser/soap in stall (1)?	
Is there a soap dispenser/soap in stall (2)?	
Is there a soap dispenser/soap in stall (3)?	
Is there a soap dispenser/soap in stall (4)?	
Is the call light in stall (1) working properly?	
Is the call light in stall (2) working properly?	
Is the call light in stall (3) working properly?	
Is the call light in stall (4) working properly?	
Is the ceiling light in stall (1) working properly?	
Is the ceiling light in stall (2) working properly?	
Is the ceiling light in stall (3) working properly?	
Is the ceiling light in stall (4) working properly?	
Are the walls in each stall clean and in good repair?	
Are the baseboards in each stall clean/in good repair?	
Are the tiles in each stall clean/in good repair?	
Is there a thermometer up? Record the temperature.	
Is there a privacy curtain up around the commode?	
Is the call light working properly at the commode?	
Does the commode flush properly?	
Is the commode and commode seat in good repair?	
Is there a tissue holder/tissue ready for use?	
Are assistive devices in place and in good repair?	
Are there any missing/damaged floor tiles?	
Are exhaust vents clean and free from dust?	
Are there any odors in the shower room?	
Are there any problems with the door?	
Are gloves available in the dispenser?	

**Good Shepherd Community Nursing Center
Quality Assurance**

Room Number: _____

Date: _____

Area	Comment/Explanation
Is ceiling clean?	
Any problems with the sprinkler head?	
Is the window clean and free of fog?	
Is the window blind clean and working properly?	
Is the window valance up and clean?	
Is the t.v. in good repair and working properly?	
Are there paper towels in the room?	
Is there soap in the dispenser?	
Is the light working above the sink?	
Is the mirror clean and in good repair?	
Is the water pressure good?	
Is there hot water in the sink?	
Is the lavatory in good repair?	
Is there a trash can in the room?	
Are wheelchairs/cushions clean and in good repair?	
Are the bedside chairs clean and in good repair?	
Are recliners/geri-chairs clean and in good repair?	
Does the overbed light work above bed one (upper/lower)?	
Does the call light work?	
Is the privacy curtain up/clean/in good repair - at bed one?	
Is the wardrobe clean/neat/in good repair for bed one?	
Is the overbed table clean/neat/in good repair for bed one?	
Is the bedside table clean/neat/in good repair for bed one?	
Are the bed linens clean on bed one?	
Is the bed frame clean/neat/in good repair for bed one?	
Are bedrails clean and do they work properly for bed one?	
Are bedrail pads clean and in good repair for bed one?	
Is the nightlight in good repair?	
Is ice water/cup available for the resident in bed one?	

Area	Comment/Explanation
Is the cup clean?	
Is the g-tube syringe clean/stored properly for bed one?	
Does the overbed light work above bed two (upper/lower)?	
Is the privacy curtain up/clean/ in good repair - at bed two?	
Is the wardrobe clean/neat/in good repair for bed two?	
Is the overbed table clean/neat/in good repair for bed two?	
Is the bedside table clean/neat/in good repair for bed two?	
Are the linens clean on bed two?	
Is the bed frame clean/neat/in good repair for bed two?	
Do the bedrails work properly for bed two?	
Are the bedrails clean on bed two?	
Is ice water/cup available for the resident in bed two?	
Is the cup clean?	
Is the g-tube syringe clean/stored properly for bed two?	
Is the floor clean? Are there any problems with the tile?	
Does the heater/cooler work properly and is it in good repair?	
Are there knobs on the heater/cooler?	
Are the walls clean and free from scratches/holes/etc.?	
Are baseboards in good repair?	
Are there any problems with the door?	
Does the bathroom light work properly?	
Does the bathroom call light work properly?	
Does the commode flush?	
Is the commode clean and in good repair?	
Are the walls clean and free of debris/scratches?	
Is the ceiling and vent clean?	
Is the sprinkler head in good repair?	
Are the floors clean and free of stains?	
Are gloves in the bathroom?	
Is there toilet tissue in the bathroom?	
Are there odors in the bathroom?	
Does the bathroom door close properly?	
Do all plug-ins have covers and light switches have plates?	

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

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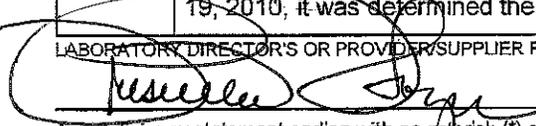
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NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD COMMUNITY NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE Division of Health Code Southern Enforcement Branch 66 PHILLIPS BRANCH ROAD, BRACK 424 PHELPS, KY 41553
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K 000	INITIAL COMMENTS	K 000		
K 066 SS=D	<p>A Life Safety Code survey was initiated and concluded on November 19, 2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview on November 19, 2010, it was determined the facility failed to</p>	K 066	<p>The self-closing device on the ashtray On B-Unit patio has been replaced.</p> <p>The self-closing devices on each patio ashtray has been inspected to insure the self-closing device is operational.</p> <p>The patio ashtrays will be monitored on a daily basis by environmental staff as they clean the patios to insure they are functioning as designed. If an ashtray is in need of repair, it will be reported to the MS immediately using the repair requisition forms that are available to all staff.</p> <p>The Environmental Supervisor will inspect the ashtrays on a monthly basis to insure compliance is maintained. Inspections will be prior to the monthly QA meeting and a report will be forthcoming in the monthly meeting.</p>	12/31/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/14/10
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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 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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K 066	Continued From page 1 ensure the facility ashtrays' self-closing devices were functioning properly. This deficiency could effect all (94) ninety-four residents and staff. The facility is licensed for 120 beds and the census on the day of the survey was (94) ninety-four. The findings include: Observation on November 19, 2010, at 12:15 p.m., revealed an ashtray attached to the outside of the building at the exit of the A/B Wing nurses' station, in the designated smoking area. The ashtray's self-closing cover device was in need of repair. This observation was confirmed with the Administrator. Interview on November 19, 2010, at 12:15 p.m., with the Administrator indicated that the ashtray's self-closing device would be repaired. Reference: NFPA Standard 101 (2000 Edition). 19.7.4 Smoking (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066			
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072			

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K 072	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the corridors were maintained free from obstructions in the case of fire or other emergency. This deficiency could affect all (94) ninety-four residents and staff. The facility is licensed for 120 beds and the census on the day of the survey was (94) ninety-four residents. The findings include: Observation on November 19, 2010, at 11:30 a.m., revealed carts in the corridors that were unattended for over 30 minutes. A clean linen cart was observed outside room 302. Another clean linen cart was observed at the exit for the C/D Wing. Clean linen carts were also observed outside of rooms 401 and 105. Further observation revealed a magazine stand in the corridor by the kitchen. These obstructions were blocking the handrail causing the handrail to be nonaccessible for resident use. These observations were confirmed with the Administrator. Interview with the Administrator on November 19, 2010, indicated that the carts and magazine stand would be moved. Reference: NFPA 101 (2000 Edition). 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	Staff were in-serviced on 12/8/10 regarding leaving carts unattended for >30 minutes. The magazine stand in the corridor by the kitchen has been moved to the T.V. lounge on C-Unit. Corridors will be kept free of items that impede accessibility to exits or handrails. Staff will insure all carts will be stored properly when not in use. Corridors will be monitored routinely by Department Supervisors for items that block the utilization of handrails; or, items that block access, egress, or visibility of exits. An investigation will be initiated of any obstruction found in the corridors. Supervisors will consistently monitor the corridors for any impediment to exit doors, handrails, or visibility to exit signage. Any problems noted will be resolved immediately by the DS. These issues will be discussed in the monthly QA meeting. If additional follow-up is warranted, meetings will be initiated immediately to resolve any issues that would prevent compliance.	12/8/10
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 073		

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NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD COMMUNITY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 60 PHILLIPS BRANCH ROAD, PO BOX 424 PHELPS, KY 41553	
(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
K 073	<p>Continued From page 3</p> <p>No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency could affect all (94) ninety-four residents and staff. The facility is licensed for 120 beds and the census on the day of the survey was (94) ninety-four residents.</p> <p>The findings include:</p> <p>Observation on November 19, 2010, at 12:00 p.m., revealed three resident rooms (211, 400, and 404) with hanging decorations on the doors that were not flame retardant. This observation was confirmed with the Administrator.</p> <p>Interview with the Administrator on November 19, 2010, at 12:00 p.m., indicated that they were unaware of the decorations on the doors.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.</p>	K 073	<p>The hanging decorations on room 211 has been removed and taken home by the family. The resident residing in room 400 went home and she took her door decoration with her. The decoration hanging on room 404 has been treated with Flame Shield from AAM Industries.</p> <p>Department Supervisors have inspected the rooms and doors of each resident for any items that are not flame retardant that could pose a risk for fire.</p> <p>A letter has been drafted and added to the Resident Handbook that asks family members to check with office staff prior to hanging items on doors or in resident rooms that pose the potential for a fire hazard. The handbook is given to the resident/family during the admission process and discussed in detail with the resident and family.</p> <p>Department Supervisors will monitor corridors and rooms daily for items that may not be flame retardant. They will routinely inspect rooms as they perform Monthly QA checks. They will report any questionable items to the ED for further investigation. Compliance will be monitored during our monthly QA meetings.</p>	12/14/10