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

Second SOD

PRINTED: 05/13/2011
FORM APPROVED
OMB NO. 0938-0391

RECEIVED MAY 22 2011 Division of Health Care Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185222		C 04/14/2011

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
F 000	INITIAL COMMENTS A complaint investigation (KY16282) was conducted on April 13-14, 2011. The allegation was substantiated with deficient practice identified. The highest scope and severity was at "D" level.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	Resident #1 was discharged to the hospital on 1/29/11 and did not return to our facility. Licensed staff have been in-serviced on 04-25-11 regarding the process of proper notification of the attending physician and the responsible party. The staff member that failed to follow our policy regarding notification of the attending physician and the responsible party has been disciplined. The administrator has pulled a log of all incidents for the months of March, April, and May. There was a total of nine residents who had sustained a fall during this period of time. The attending physician as well as the family member/responsible party has been contacted by the administrator to insure they received timely notification of these falls. A form (Resident Fall Follow-up) was completed on each resident that sustained a fall. Contact was successful on 7 of the 9 residents. Messages were left on two occasions for the family members of the other two residents. An additional family was contacted for a resident who had a fall in February. The results of each call indicated they had been contacted regarding the falls except for one family member who indicated that she was called each time her mother was sent out for dialysis and when she returned to the facility; however, she could not remember for certain that she was called in March regarding a fall her	05-13-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Russell [signature] TITLE: Administrator (X6) DATE: 5/21/11

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 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to immediately notify the resident's physician and the resident's responsible party (RP) when there was an accident/incident involving the resident that had potential for requiring physician intervention for one of three sampled residents (resident #1). Resident #1 sustained a fall at the facility on January 29, 2011. However, the facility failed to inform the resident's physician and RP of the resident's fall. The findings include: Review of the facility's Falls Policy, dated August 2009, revealed the resident's family and the attending physician were to be notified when a resident sustained a fall. Review of the medical record for resident #1 revealed the resident was admitted to the facility on August 4, 2010, with diagnoses to include Congestive Heart Failure (CHF), Hypertension, Diabetes Mellitus, Osteoarthritis, Iron Deficiency Anemia, Kidney Failure, and Chronic Obstructive Pulmonary Disease (COPD). Review of resident #1's medical record further revealed resident #1 sustained a fall on January 29, 2011, at 12:45 p.m. Further review of resident #1's medical record revealed the facility notified resident #1's physician at 12:45 p.m. on January 29, 2011, of a decrease in the resident's level of consciousness, weakness, and that the	F 157	F 157 Continued mother sustained. She indicated that it had been too long for her to remember. She did say the staff were always good to call her and let her know anything that was going on with her mother. The QA Coordinator has computer access to all incidents and can readily review the documentation of each incident to insure the attending physician and the family member/responsible party has been notified. In addition, the QA Coordinator will follow up on each resident that sustains a fall. She will call the attending physician and the family member/responsible party within 72 hours of the fall to insure notification has been made. In the absence of the QA Coordinator, the Director of Nursing or the Administrator will make the calls. The QA coordinator will complete a form (Resident Fall Follow-up) for each resident that sustains a fall. The calls will be placed for a period of three months (May, June, July, and August) and the forms completed. If 100% compliance is sustained for a period of three months, follow up calls will be discontinued; however, random calls (2-3 each month) will be placed to insure compliance is maintained. The forms will be reviewed each week by the QA committee and will be filed in a three ring binder. At the conclusion of each month, the forms will be attached to the	

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F 157	Continued From page 2 resident's lungs had audible rhonchi. However, there was no documentation provided to indicate resident #1's physician had been notified of the resident's fall. Further review of resident #1's medical record revealed the resident's RP was notified at 1:00 p.m. on January 29, 2011, related to resident #1's decrease in level of consciousness, weakness, and lung sounds. However, there was no documentation provided that the resident's RP had been notified of the resident's fall. Interview with Licensed Practical Nurse (LPN) #1 on April 13, 2011, at 5:16 p.m., revealed LPN #1 provided care for resident #1 on January 29, 2011, the day the resident sustained a fall. Interview further revealed the LPN had notified resident #1's physician on January 29, 2011, of audible rhonchi in the resident's lungs, shortness of breath, and a change in the resident's level of consciousness. However, LPN #1 could not recall if the physician had been notified of the resident's fall. LPN #1 further stated resident #1's RP had not been notified of the resident's fall on January 29, 2011. Interview with the Director of Nursing (DON) on April 13, 2011, at 9:00 p.m., revealed it was the responsibility of the nurse who provided care for the resident to notify the physician and the RP of accidents/incidents. The DON further stated the fall resident #1 sustained on January 29, 2011, should have been reported to the resident's physician and RP.	F 157	F157 Continued monthly QA report.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

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F 279	Continued From page 3 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 interview and record review the facility failed to use the resident Assessment Instrument (RAI) to review and revise the resident's comprehensive care plan (CCP) for one of three sampled residents (resident #1). The facility failed to individualize resident #1's CCP for falls and activities of daily living related to the number of staff needed to assist resident #1 with transfers and activities of daily living. The findings include: Based on medical record review, resident #1 was admitted to the facility on August 4, 2010, with	F 279	The comprehensive care plan for each resident has been individualized to reflect the needs for activities of daily living along with staffing needed for transfers, toileting and resident safety. The comprehensive care plan (Daily Care Guide) for each resident has been reviewed and individualized by MDS staff to reflect the number of CNA's needed for transfer, bathing, dressing, eating, and toileting, along with safety devices and appliances needed. The plan also addresses specific risks and interventions of each resident. For each admission or readmission to the facility, the admitting nurse will be responsible for devising/updating a Daily Care Guide for each resident. Upon completion of the first MDS, the IDT team will meet to individualize the plan and detail the needs of each resident. As changes occur, the guide will be updated by the charge nurse to reflect the change and the needs of each resident. Upon admission/readmission, the DON and ADON will review the Daily Care Guide that has been developed to insure it is in place and it accurately details the needs of the resident. Compliance will be monitored by the DON and ADON. For each admission/ readmission, the Daily Care Guide will be reviewed by the DON and	05-13-11

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F 279	Continued From page 4 diagnoses that included Congestive Heart Failure (CHF), Diabetes Mellitus (DM), Vertigo, Chronic Obstructive Pulmonary Disease (COPD), and Renal Failure. Review of resident #1's quarterly Minimum Data Set dated January 17, 2011, revealed the facility assessed resident #1 to require extensive assistance of two staff members for transfers, ambulation, and when moving on and off the toilet due to the resident's unsteady gait. Review of resident #1's CCP dated August 17, 2010, and reviewed on January 13, 2011, revealed resident #1 had been assessed to be at risk for falls due to resident #1's unsteady gait, impaired mobility, antidepressant medication use, and vertigo. Interventions the facility put into place for resident #1 were to provide resident #1 with physical assistance and/or support of staff for transfers, ambulation, and/or locomotion as needed. Review of the CCP for impaired physical mobility dated August 17, 2010, and reviewed January 13, 2011, revealed the facility developed interventions for resident #1 including the assistance of staff for transfers as needed. Further review of the CCP related to the resident's risk for alteration in bowel elimination and/or self-care deficit and toileting revealed the facility's interventions included assistance with toileting, and transfers on/off the toilet. However, the facility had not individualized the CCP to address resident #1's assessed need of two staff members for all transfers, ambulation, and toilet use at all times. Interview with LPN #2 on April 13, 2011, at 7:00 p.m., revealed the LPN performed MDS	F 279	F279 Continued ADON for completion and accuracy. Additionally, two residents will be randomly selected for review each week to insure any changes in needs have been addressed by the charge nurse. The DON and ADON along with the IDT will present to the selected resident's rooms to assess the resident and review the Daily Care Guide. Any revisions/updates will be documented on the Daily Care Guide and a copy made for review by the QA committee.	

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F 279	Continued From page 5 assessments and developed care plans related to residents' needs. LPN #2 stated staff interviews related to resident needs were utilized to assist the LPN in the development of care plans. Further interview with LPN #2 revealed if a resident was assessed to require extensive assistance of two staff members with toileting, there should be two staff members with the resident at all times during toileting. Interview further revealed if a resident was assessed to be at risk for falls, a care plan related to falls would be developed. Review of the nurse aide care plan dated November 2, 2010, for resident #1 revealed there was no documentation related to the number of staff required to assist resident #1 with transferring, ambulation, and toileting. Review of resident #1's medical record and incident report dated January 29, 2011, revealed resident #1 sustained a fall from the toilet on January 29, 2011. Further review of the incident report revealed resident #1 had been assisted to the toilet by one staff member and the staff member had left the resident alone in the restroom. Interview with certified nursing assistant (CNA) #2 (who provided care for resident #1 on January 29, 2011) on April 13, 2011, at 7:30 p.m., revealed resident #1 needed two staff members to assist with toileting and transfers. CNA #2 stated if the resident was "not going to be in there long" two staff members would stay with the resident. However, according to the CNA, if the resident was going to be in the restroom a long time, only one staff member stayed. CNA #2 went on to	F 279		

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F 279	Continued From page 6 state that on January 29, 2011, only one staff member had assisted resident #1 to the restroom. CNA #2 further stated that if the resident utilized a walker then one staff member would assist the resident with the use of the walker. Further interview revealed CNA #2 was not aware if resident #1 had been assessed or care planned for fall risks. The CNA stated if the resident was assessed and care planned as at risk for falls, staff was not to let the resident out of their sight. Interview with CNA #3 on April 13, 2011, at 7:06 p.m., revealed staff placed nurse aide care plans in the closet in each resident's room. CNA #3 further stated the care plan revealed the number of staff required to assist each resident with toileting and transfers. However, CNA #3 reviewed the nurse aide care plan for a random resident and was unable to find where the care plan stated how many staff was required to assist the resident with transfers and toileting. Interview with the Director of Nursing (DON) and Assistant DON on April 13, 2011, at 9:00 p.m., revealed the facility required two staff members to go into a resident's room for all activities of daily living care, for the resident's and the staff member's "safety." The DON further stated that the DON had been made aware that only one nurse aide had transferred and toileted resident #1 at the time of resident #1's fall on January 29, 2011. Interview with the Administrator on April 13, 2011, at 9:34 p.m., revealed two staff members were required to go into resident rooms for activities of daily living care. The Administrator stated that	F 279		

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F 279	Continued From page 7 once the resident was assisted to the toilet one of the staff members was permitted to leave. The Administrator further stated that the Administrator was not aware if the second staff member would then come back and assist with transferring the resident back to bed or not.	F 279		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure each resident received adequate supervision and assistance to prevent accidents for one of three sampled residents (resident #1). The facility assessed resident #1 as a falls risk, and to require extensive assistance of two staff members for all transfers and toileting. However, on January 29, 2011, while being assisted by one staff member resident #1 sustained a fall. The findings include: Review of the facility's fall protocol revealed as part of a resident's initial assessment, the physician would help the facility staff identify individuals with a history of falls and risk factors for subsequent falling. The facility policy further revealed the facility staff would document risk	F 323	Staff have been instructed to follow the plan of care that has been developed in the Daily Care Guide for each resident which specifically addresses the number of staff and the equipment necessary for safely transferring, toileting, and providing assistance with ADL's. A copy of the Daily Care Guide is enclosed. The CNA that failed to follow the POC for the resident has been disciplined. The Daily Care Guide has been updated for each resident which reflects the equipment and the number of staff needed to provide assistance to each resident for safely transferring, toileting, and ADL's. All staff have been advised of the updated Daily Care Guide for each resident. Staff have been in-serviced on 5-12-11 regarding the expectations required of them concerning the Daily Care Guide, and the consequences of failing to follow the directions set forth in the guide. As a safety precaution, two staff members are required to be present for transfers, toileting, and ADL's.	5-13-11

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F 323	Continued From page 8 factors for falling in the resident's record. Further review of the facility policy revealed the physician would identify medical conditions affecting fall risk and the risk for significant complications of falls. Based on medical record review, resident #1 was admitted to the facility on August 4, 2010, with diagnoses to include Congestive Heart Failure (CHF), Diabetes Mellitus (DM), Vertigo, Chronic Obstructive Pulmonary Disease (COPD), and Renal Failure. Review of resident #1's "Fall Risk Evaluation," dated January 12, 2011, revealed the facility assessed resident #1 to be at risk for falls due to the resident's impaired vision, problems with ambulation, and the facility's inability to assess the resident's balance due to the resident's need for physical assistance. In addition, the resident had been assessed to have three or more health conditions and received three or more medications that placed the resident at risk for falls. Based on the assessment, the resident's score of 20 met the facility's criteria of a score of 10 or more to identify residents that were at risk for falls. Review of resident #1's quarterly Minimum Data Set dated January 17, 2011, revealed the facility assessed resident #1 to require extensive assistance of two staff members for transfers, ambulation, and toilet use. Further review of the MDS dated January 17, 2011, revealed the facility assessed resident #1 to have an unsteady gait and, when moving on and off the toilet, required human assistance due to the resident being unsteady.	F 323	Continued from F323 Compliance will be monitored by our licensed staff and QA committee. CNA staff will be observed as they render care to the residents to insure the Daily Care Guide is being used as a tool for the care, assistance needed, and any devices needed to insure the safety of the resident. Monitoring staff will be asked to review the guide, observe at least one interaction between a resident who has been assessed as being at risk for falls and a CNA on a daily basis, and to ask questions of the CNA about the needs of each resident. Any observed deviation from the guide will be immediately addressed with the CNA, documented on a copy of the guide, and followed up by the DON or ADON. The QA committee will meet weekly to to review any documented issues, and take action to insure the safety of each resident.	

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F 323	Continued From page 9 Review of resident #1's "Resident Incident Report," dated January 29, 2011, revealed resident #1 sustained a fall on January 29, 2011, at 12:45 p.m. Further review of the incident report revealed one staff member had assisted resident #1 to the bathroom and had left the bathroom area to give the resident "some privacy." Based on documentation, the staff member returned to the bathroom and found resident #1 lying on the floor. The resident had reportedly become weak and fell to the floor from the toilet. Continued review of the incident report revealed resident #1's physician was contacted on January 29, 2011, at 12:45 p.m., due to a decrease in the resident's level of consciousness, audible rhonchi in the resident's lungs, and that the resident had stated that he/she felt funny. Resident #1 was transferred at 1:40 p.m. on January 29, 2011, to a hospital for further evaluation and treatment. Review of resident #1's hospital records from January 30, 2011, revealed resident #1 had an enlarged raised area with a "bluish tint" to the right forehead. A report of a Computed Tomography (CT) scan of resident #1's head performed on January 31, 2011, was reviewed and revealed a large soft tissue swelling/hematoma noted over the right forehead. The CT scan report further revealed no evidence of a subdural hematoma or fracture. Interview with certified nursing assistant (CNA) #2 on April 13, 2011, at 7:30 p.m., revealed the CNA assisted resident #1 to the bathroom on January 29, 2011. The CNA stated resident #1 required the assistance of two staff members for toileting and transfers. CNA #2 stated he/she assisted	F 323		

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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 C 04/14/2011
NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD COMMUNITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 80 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
F 323	Continued From page 10 resident #1 to the restroom, adjacent to the resident's room, on January 29, 2011, with no other staff assistance present. CNA #2 further stated on occasions resident #1 was able to walk with the assistance of one staff person and a walker, and that resident #1 was "usually steady" on the toilet. The CNA stated he/she left the resident unattended on the toilet and went into the resident's bedroom. The CNA stated he/she heard a noise coming from the bathroom, went into the bathroom, and observed the resident lying on the floor and notified the nurse. Interview with Licensed Practical Nurse (LPN) #2 on April 13, 2011, at 5:16 p.m., revealed CNA #2 had notified the LPN of resident #1's fall on January 29, 2011. Further interview with LPN #2 revealed resident #1 required the assistance of two staff members for toileting. Interview with the Director of Nursing (DON) on April 13, 2011, at 9:00 p.m., revealed the facility required two staff members to go into a resident's room for all activities of daily living care, for the resident's and the staff member's "safety." The DON further stated that the DON was aware only one nurse aide was transferring and toileting resident #1 at the time of resident #1's fall. Interview with the Administrator on April 13, 2011, at 9:34 p.m., revealed two staff members were required to go into resident rooms for activities of daily living care. Further interview revealed the Administrator was under the impression two staff members assisted resident #1 to the restroom on January 29, 2011, and one staff member left the room while the other staff member stayed with the resident.	F 323		

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

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	185222		C 04/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD COMMUNITY NURSING CENTER	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

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