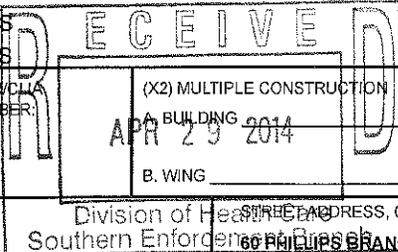


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/17/2014
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 04/03/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD COMMUNITY NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE Division of Health Care Enforcement Southern Enforcement Branch 60 PHILIPS BRANCH ROAD 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
F 000	INITIAL COMMENTS	F 000		
F 253 SS=D	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy, it was determined the facility failed to provide maintenance and housekeeping services to maintain a sanitary, orderly, and comfortable interior. Observations during the environmental tour on 04/01/14 at 11:05 AM revealed one (1) of four (4) shower chairs in the C/D Wing women's shower room had a worn/threadbare mesh back and was available for resident use.</p> <p>The findings include: Review of the "Maintenance Service" policy (dated December 2011) revealed the Maintenance Department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Observation on 04/01/14 at 11:05 AM revealed a shower chair, available for use in the women's C/D Wing shower, had a mesh back that was threadbare and worn.</p>	F 253	<p>The shower chair has been removed from service and taken to the maintenance room for replacement of the mesh backing of the chair.</p> <p>All equipment in the building has been inspected by department supervisors. Any items identified for repair/replacement have been removed from service and taken to the maintenance room. An in-service was conducted on 4-24-14 (see attached documentation) with all staff. They were informed that safety is the main responsibility of all employees. Employees were reminded of the importance of completing repair requisitions and were instructed it was everyone's responsibility to immediately remove any equipment that is in need of repair from the work area to avoid use and the potential for injury to the resident, themselves, co-workers, or visitors. When removing equipment from the work area to the maintenance room, staff will attach a STOP alert to the equipment and will identify on the back of the alert form the cause for repair (what is broken/wrong) with the equipment.</p> <p>A form has been drafted for the inspection of shower rooms/equipment by the oncoming nurse prior to accepting the responsibility of the floor (see attached form). The forms will be attached to the twenty four hour report forms that are provided to the DON each morning. The form will be secured, monitored, and kept on file by the environmental supervisor who will insure the forms are complete and that proper action has been taken when indicated. The charge nurses will insure that all equipment in</p>	4-25-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Executive Director* (X6) DATE: *4/25/14*

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 253	Continued From page 1 Interview with RN #1 on 04/01/14 at 3:00 PM revealed if repairs were needed a requisition form detailing the needed repair was sent/given to the Maintenance Department. The Maintenance Director would then complete the needed repairs. According to RN #4, the shower chair in the women's shower room should have been taken out of service. Interview with the Housekeeping Supervisor on 04/03/14 at 11:30 AM revealed housekeepers cleaned the shower rooms every day, and part of the cleaning staff duties was to observe shower chairs for cleanliness and for any needed repairs. In addition, staff made rounds on a daily basis and the shower chair was not identified as being worn or threadbare. According to the Housekeeping Supervisor, the C/D Wing women's shower room chair should have been removed from the floor due to the worn/threadbare mesh backing. Interview with the Maintenance Supervisor on 04/03/14 at 11:45 AM revealed the Maintenance Department had not received a work order for the needed repairs on the shower chair. Interview with the Administrator on 04/03/14 at 2:45 PM revealed the shower chair should not have been in the shower room available for resident use. The Administrator said daily rounds were completed to check for needed repairs and the chair had not been identified as a problem.	F 253	F253 Continued the shower rooms is sound and ready for use. Any items in need of repair will be immediately removed from any/all areas of the building and taken to the maintenance room for repair/replacement. In addition, the environmental supervisor will also complete random weekly inspections of the shower rooms (see attached form). Any identified problems will be immediately addressed and brought to the attention of the Administrator. All repair requisitions completed by staff members will be reviewed by the Administrator. Equipment will be inspected on a monthly basis by department supervisors who are assigned to specific areas utilizing facility QA forms (see attached forms). Any equipment that is in need of repair will be immediately removed from the service area and taken to the maintenance room for repair/replacement. Copies of the completed QA forms will be provided to the administrator by the 25 th of each month and will be reviewed at the monthly QA/Safety meetings. Random inspections of the building will be completed by the Administrator, QA Coordinator, and DON. If problems are identified, they will be addressed immediately and also brought to the attention of staff members working in that specific area. Continuing education will be provided to all staff members to alert them to be more diligent in their efforts to provide a safe environment for everyone.		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282			

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F 282	<p>Continued From page 2</p> <p>must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure care plan interventions were implemented for one (1) of nineteen (19) sampled residents (Resident #1). The comprehensive care plan included an intervention to ensure the Foley catheter was secured for Resident #1; however, facility staff failed to secure the catheter on 04/02/14.</p> <p>The findings include:</p> <p>Review of the "Care Plan" policy (dated December 2011) revealed the care plan would be used to develop the resident's daily care routines.</p> <p>Review of the medical record revealed the facility admitted Resident #1 on 10/01/08 with diagnoses including Alzheimer's disease, Diabetes Mellitus, Atrial Fibrillation, Coronary Artery Disease, History of Prostatic Cancer, and Chronic Kidney Disease. According to the Minimum Data Set (MDS) dated 01/27/14, Resident #1 required an indwelling urinary catheter due to Chronic Kidney Disease and History of Prostatic Cancer. Review of the comprehensive care plan revealed interventions included positioning the catheter tubing for proper drainage and to secure the catheter to minimize tension.</p> <p>Observation of Foley catheter care was conducted on 04/02/14, at 12:50 PM, with</p>	F 282	<p>A leg band was placed on resident #1 as directed by the plan of care (daily care guide) to secure the catheter to prevent tension/trauma/pain and to allow for proper drainage.</p> <p>The care plan for each resident that has a catheter in place has been reviewed to ensure it addresses that a leg band must be used to secure the catheter tubing. Staff were in-serviced on 4-24-14 regarding the importance of following the plan of care for each resident and that failure to do so can result in serious consequences for the resident as well as the staff member that fails to follow proper procedure.</p> <p>The task of using a leg band to secure the catheter tubing has been flagged by the MDS coordinators on the KIOSK and SRNA's cannot close out their shift on the KIOSK without specifically documenting the catheter plan of care for that resident has been followed (a reminder to insure compliance). The SRNAS were in-serviced on 4-24-14 and advised to review the daily care guide on a daily basis to insure the plan of care is followed as directed and that they are aware of any changes made to the daily care guide. We will continue to educate all SRNAS on the importance of reviewing the daily care guide in order to follow the plan of care specifically designed for each resident.</p> <p>The MDS staff and QA Coordinators will audit five SRNAS/residents each week to ascertain the plan of care designed for that resident is being followed. They will offer support and direction to the staff and will provide a report to the QA committee on their findings. Additional training will be provided to staff based on their findings and as needed.</p>	4-25-14	

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F 282	Continued From page 3 Certified Nursing Assistant (CNA) #1. No problems were observed during the Foley catheter care; however, the CNA failed to secure the catheter to prevent pulling and/or possible injury to the resident after Foley catheter care was completed. After catheter care was completed, the CNA was observed to place a clean brief on the resident and replace the resident's jogging pants with the catheter tubing inserted through the legging of the jogging pants and the Foley catheter bag anchored at the resident's bedside. Interview conducted with CNA #1 on 04/03/14, at 3:20 PM, revealed the CNA was aware of the care plan intervention to secure the catheter tubing. The CNA stated she had been trained to use a leg strap to anchor/secure the catheter for residents; however, CNA #1 stated she had removed the leg strap earlier in her shift due to soilage and "forgot" to obtain a new leg strap. The Director of Nursing (DON) stated in interview on 04/03/14, at 4:00 PM, the CNAs were responsible to implement the care plan interventions. The DON further stated nurses were responsible for monitoring residents with catheters to ensure the catheter was secured to prevent pulling and/or possible injury to the resident. The DON confirmed a leg strap should have been used to secure the catheter for Resident #1.	F 282			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315			

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F 315	<p>Continued From page 4</p> <p>indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure appropriate treatment and services were provided to prevent an injury of the urinary tract for one (1) of nineteen (19) sampled residents (Resident #1). Facility staff failed to ensure the Foley catheter was secured for Resident # 1.</p> <p>The findings include:</p> <p>Review of the "Foley Catheter" policy (dated December 2011) revealed the catheter should be taped to the top of the resident's thigh or lower abdomen and the catheter tubing should be secured to the bottom bed sheet with a clip provided with the drainage set.</p> <p>Review of the medical record revealed the facility admitted Resident #1 on 10/01/08 with diagnoses including Alzheimer's disease, Diabetes Mellitus, Atrial Fibrillation, Coronary Artery Disease, History of Prostatic Cancer, and Chronic Kidney Disease. Review of the Minimum Data Set (MDS) dated 01/27/14, revealed the facility assessed Resident #1 to require extensive assistance with toileting needs and required an indwelling urinary catheter due to Chronic Kidney</p>	F 315	<p>A leg band was placed on resident #1 to anchor the tubing of his catheter in an effort to avoid trauma/pain/tension and to allow for proper drainage.</p> <p>A catheter listing was pulled from the Physician Orders List in AHT which listed all residents who have catheters in our building. All residents on the list were checked for proper anchoring of the catheter tubing by use of a leg band. The process has been repeated on four different occasions since 4/3/14 and all residents on the list had the necessary leg bands in place.</p> <p>An order for a leg band to be applied to the tubing of a foley catheter for proper anchoring will be added to the electronic TARS. The LN will observe the leg band for proper anchoring prior to signing the TAR. Any identified problems will be addressed immediately and then reported to the Quality Assurance Coordinator for follow-up.</p> <p>The catheter listing will be pulled three times a week for the next two weeks. Residents who have a catheter in place will be checked by the Administrator, DON, and QA Coordinator to insure that a leg band has been applied to anchor the tubing of the catheter. If compliance is maintained, listings will be pulled on a monthly basis to insure continued compliance is maintained. A report will be provided to the Quality Assurance Committee and reviewed on a monthly basis. If indicated, additional training will be provided by the QA Coordinator.</p>	5-9-14	

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F 315	<p>Continued From page 5</p> <p>Disease and History of Prostatic Cancer. Review of the comprehensive care plan revealed the facility addressed the use of the Foley catheter for Resident #1. Care plan interventions included to position the catheter tubing for proper drainage, and to secure the catheter to minimize tension.</p> <p>Observation of Foley catheter care was conducted on 04/02/14, at 12:50 PM, with Certified Nursing Assistant (CNA) #1. No problems were observed during the Foley catheter care; however, the CNA failed to secure the catheter to prevent pulling and/or possible injury to the resident after Foley catheter care was completed. After catheter care was completed, the CNA was observed to place a clean brief on the resident and replaced the resident's jogging pants with the catheter tubing inserted through the legging of the jogging pants and the Foley catheter bag anchored at the resident's bedside.</p> <p>Interview conducted with CNA #1 on 04/03/14, at 3:20 PM, revealed the CNA had been trained to use a leg strap to anchor/secure the catheter for residents. CNA #1 stated she had removed the leg strap earlier in her shift due to soilage and "forgot" to obtain a new leg strap.</p> <p>The Director of Nursing (DON) confirmed in an interview conducted on 04/03/14, at 4:00 PM, that the CNA should have used a leg strap to secure the catheter for Resident #2. The DON stated the nurses should monitor residents with catheters to ensure the catheter was secured to prevent pulling and/or possible injury to the resident. The DON further stated no problems had been reported to her.</p>	F 315			

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F 469 SS=D	<p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy it was determined the facility failed to maintain an effective pest control program to ensure the facility was free of pests. Observations on 04/03/14 revealed black ants, too numerous to count, on the windowsill in room 205 on a hummingbird feeder (that had been brought inside for the winter). In addition, four black ants were observed on the floor, bedside table, and on the wound dressing of Resident #16 in room 206.</p> <p>The findings include:</p> <p>Review of the Pest Control Service Agreement dated 07/24/95 revealed pest control services would be provided to the facility for roaches, ants, silverfish, rats, mice, and spiders once every month.</p> <p>Review of the bill of services from the pest control company dated 03/18/14 revealed a bill for the placement of ant baits in resident rooms.</p> <p>Observations on 04/03/14 at 11:05 AM of Resident #16 and the resident's room (room 206-2) revealed two black ants on the resident's floor, one black ant on the bedside table, and one</p>	F 469	<p>The Hummingbird Feeder was removed from room 205. Housekeeping cleaned rooms 205 and 206 to rid the rooms of the ants. Orkin was called and responded on 4-3-14 to treat the facility for the ants (in particular rooms 205 and 206). Nursing staff contacted the primary care physician and received an order to remove the bandages from the leg of resident #16 to insure no pests were under the bandages or within the bandages. Staff were instructed to clean Hummingbird Feeders with hot, soapy water, and to store them in the activity storage building located outside of the facility.</p> <p>Each room in the building has been carefully inspected by department supervisors and other staff for additional pests. No other rooms were noted to have ants or other pests.</p> <p>An in-serviced was conducted on 4-24-14 with all staff. They were asked to be observant for pests and to immediately report any issues to the maintenance director via word of mouth, followed by written requisition, and to report it to their immediate supervisor as well. Orkin has been contacted (Leonard at 606-437-0431) and the building will be treated on the outside again this year. Maintenance staff will caulk the windows, around PTAC units, and seal any areas along the flooring that could allow for pests to penetrate the building. Housekeeping and nursing staff will be asked to monitor the floors for spills and to keep sweet, sticky spills mopped up timely. Resident snacks will be stored in plastic containers. Any food item that is not completely consumed will be discarded in proper containers and removed from the resident rooms to avoid the attraction of pests.</p> <p>The Administrator, DON, and the Quality Assurance Coordinator will do weekly walks through each room in the building specifically looking for pests or the indication of pests. As we walk, we will check with the residents, family</p>	5-9-14	

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F 469	<p>Continued From page 7</p> <p>black ant on the dressing on the resident's left leg. Resident #16's physician was notified on 04/03/14 at 11:28 AM of the ants to the resident's left leg dressing and orders were received to remove the dressing and observe for ants. Resident #16's dressing was removed with no ants found in the wound or on the dressings.</p> <p>Observations of room 205 on 04/03/14 at 11:30 AM revealed black ants on the windowsill, too numerous to count, covering a hummingbird feeder.</p> <p>Interview with Resident #16 on 04/03/14 at 11:25 AM revealed previously there had not been any ants in the room and the resident had not had a problem with ants.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 and LPN #3 on 04/03/14 at 11:26 AM revealed they had not noticed any ants in the building. According to the LPNs, there were no changes in Resident #16's wound.</p> <p>Interview with Housekeeper #1 on 04/03/14 at 11:30 AM revealed ants had not been a problem in the facility, but she stated she cleaned the ants from the windowsill of room 205.</p> <p>Interview with the Housekeeping Supervisor on 04/03/14 at 11:35 AM revealed the Housekeeping Supervisor accompanied the pest control company while they were in the facility and verified that they sprayed the facility monthly. The pest control company had been to the facility on 03/18/14 for a routine visit and placed ant baits (paste) in several resident rooms for black ants.</p>	F 469	F469 Continued		
			members, visitors, and staff members asking if they have noticed any pest problems in the building. Problems will be recorded and addressed immediately. Updates will be provided to the Quality Assurance Committee and reviewed at each monthly meeting.		

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F 469	Continued From page 8 Interview with the Administrator on 04/03/14 at 2:45 PM revealed the pest control company sprayed monthly on the outside of the building and placed bait on the inside of the building. Bait had been placed in several rooms on 03/18/14 during the routine visit. The Administrator said she was not aware that there were ants in the building.	F 469			