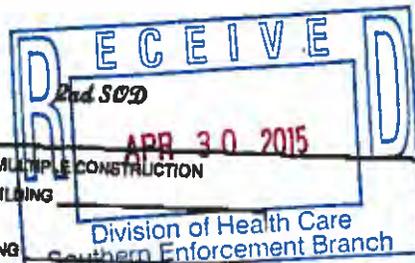


DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CENTERS FOR MEDICARE & MEDICAID SERVICES



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 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	(X3) DATE SURVEY COMPLETED C 03/04/2015
NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD COMMUNITY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 50 PHILLIPS BRANCH ROAD 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	F 000		
F 225 SS=E	<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</p>	F 225	<p>The allegations of resident #1 and resident #2 have been investigated by the Offices of Inspector General, Adult Protective Services - Protection and Permanency, and the area Ombudsman.</p> <p>Abaqls interviews for the past year with residents and families were pulled and reviewed regarding abuse questions and no reports of abuse had been made by any resident or family member. Resident Council Meetings were pulled and reviewed for the past year and no complaints of abuse were made by any resident in attendance (abuse is always discussed with the group at the close of each meeting). In addition, each resident or family member (if the resident is unable to answer) will be interviewed again using the Abaqls screening questions (see attached). Any yes answers will be reported immediately to Central Intake, Protection and Permanency/Adult Protective Services, the Office of Inspector General, and the area Ombudsman per attached policy (by phone, fax, or email). The alleged perpetrator will be removed from the premises immediately. An investigation will commence immediately and actions will be taken to protect all residents during the investigation process.</p> <p>Staff have been in-serviced on three occasions during the month of March on the importance of reporting allegations timely (the removal of the alleged perpetrator from the premises to prevent the possibility of other residents being abused) and the importance of reporting all allegations to</p>	05-8-15

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:

TITLE: Administrator
 DATE: 4/29/15

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 41563		
(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>representative and to other officials in accordance 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, facility policy review, and facility abuse investigation review, it was determined the facility failed to ensure all alleged violations involving mistreatment, neglect, or abuse were reported immediately to the administrator of the facility and to state agencies for two (2) of three (3) sampled residents (Resident #1 and Resident #2). Review of a facility investigation dated 02/19/15, revealed State Registered Nursing Assistant (SRNA) #2 and SRNA #3 reported to the Administrator at approximately 11:35 AM, that they observed SRNA #1 place a sock in Resident #1's mouth at approximately 8:15 AM. However, staff did not report the incident until approximately three (3) hours and twenty (20) minutes later. SRNA #1 continued to provide resident care during that time. In addition, review of facility investigations dated 02/19/15 and 03/02/15, revealed Resident #2 made allegations of abuse to staff. The investigations revealed the incidents were investigated and determined to be unsubstantiated; however, state agencies were not notified of the allegations.</p> <p>The findings include: Review of a facility policy titled "Abuse Policy," with a revision date of January 2014, revealed the</p>	F 225	<p>F225 Continued</p> <p>the proper authorities for investigation. Our policy for reporting allegations immediately has become more stringent and staff are aware that failure to report allegations immediately can result in termination from employment. When a resident reports an allegation to staff they are to report the allegation immediately to the administrator. The administrator or designee will:</p> <ol style="list-style-type: none"> 1) Insure the safety of the resident. 2) Remove the alleged perpetrator from the premises. 3) Call the Office of Inspector General and file a preliminary report – fax a self-reported incident form to the Office of Inspector General if the incident occurs after working hours or on weekend – follow-up with a call during the next work day. 4) Call Adult Protective Services/Offices of Protection and Permanency and file a report – send an email if after working hours or on weekends. Follow up with a call during the next work day. 5) Call the area Ombudsman and file a report – send an email if after working hours or on weekends. Follow up with a call during the next work day. 6) Email a report to Central Intake if the incident occurs after hours or on weekends. Follow up with a call on the next work day. 7) Call a report in to the Kentucky State Police if the incident occurs on weekends, after work hours, or as indicated (i.e. rape). <p>To maintain compliance and follow Kentucky Statutes, the administrator acknowledges that any and all allegations must be reported timely via telephone, fax, or email to the Office of Inspector General, Adult Protective Services – Protection and Permanency, the area Ombudsman, the</p>		

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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 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 225	<p>Continued From page 2</p> <p>Administrator must be notified immediately of any suspected abuse or incidents of abuse. The policy also revealed any individual observing an incident of abuse must immediately report the incident. The policy revealed all reports of resident abuse, neglect, and injuries of unknown origin would be promptly and thoroughly investigated by facility management and would be reported to state agencies as required.</p> <p>1. Review of the medical record for Resident #1 revealed the facility admitted the resident on 01/24/14, with diagnoses that included Dementia, Osteoarthritis, and Chronic Pain.</p> <p>Review of a significant change Minimum Data Set (MDS) assessment for Resident #1 dated 02/11/15, revealed Resident #1 was assessed by the facility to have a Brief Interview for Mental Status (BIMS) score of 3 which indicated the resident had severely impaired cognition. The MDS also revealed the resident to require the total assistance of two staff persons for bed mobility and transfers.</p> <p>Review of a facility investigation dated 02/19/15, revealed State Registered Nursing Assistant (SRNA) #2 and SRNA #3 reported an incident of abuse to the Administrator at approximately 11:35 AM. The investigation stated SRNA #2 and SRNA #3 observed SRNA #1 place a sock in Resident #1's mouth at approximately 8:15 AM. However, staff did not report the incident until approximately three hours and twenty minutes later.</p> <p>Observation of Resident #1 on 03/04/15, at 5:15 AM, revealed the resident was laying on his/her left side in bed, with full padded side rails raised</p>	F 225	<p>F225 Continued</p> <p>Kentucky State Police, and Central Intake by the facility Administrator, Social Services Director, or the Director of Nursing. Information gathering will then be initiated to secure the necessary documents for conducting a thorough investigation. The Administrator, Social Services Director, and the Director of Nursing will monitor all allegations to insure compliance is maintained and all allegations are reported to the proper agencies for investigation. The Allegation Check List will be initiated by the administrator, Social Services Director, or the Director of Nursing (the leading investigator) upon receipt of an allegation. As the necessary contacts are made, the form will be completed by the leading investigator (the form should be completed within 72 hours of the initial allegation). The form will become part of the allegation file. All allegations are primarily investigated by the administrator, the social services director, and the director of nursing who work as a team to interview, gather information, provide instructions, and develop plans to insure the safety of all the residents entrusted in our care. The investigating team will also collaborate and review the check list within 72 hours of an allegation to insure all contacts have been made and documented.</p>		

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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 41553
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F 225	<p>Continued From page 3</p> <p>on both sides. There were no apparent injuries noted.</p> <p>Multiple attempts to contact SRNA #1 were unsuccessful. Review of the facility's investigation dated 02/19/15, revealed a witness statement written and signed by SRNA #1 stating he placed the sock in Resident #1's mouth because he had a headache and the resident was screaming and would not stop.</p> <p>Interview conducted with SRNA #2 on 03/04/15, at 8:53 AM, revealed she was providing care for Resident #1 on 02/19/15 with SRNA #1. SRNA #2 further stated SRNA #3 came into the room and they both observed Resident #1 with a sock in the resident's mouth that was placed there by SRNA #1. SRNA #2 stated she was aware the incident should have been reported immediately to the administrator, but did not because she knew SRNA #1 would lose his job and she was concerned for him. SRNA #2 stated she later talked with SRNA #3 and decided they had to report the incident.</p> <p>Interview conducted with SRNA #3 on 03/04/15, at 7:12 AM, revealed at approximately 8:00 AM to 8:15 AM on 02/19/15, she entered Resident #1's room and observed the resident with a sock in his/her mouth. SRNA #3 stated she immediately told SRNA #1, "Oh my God! What are you doing? Don't you know that's a form of abuse?" SRNA #3 stated SRNA #1 immediately took the sock out of Resident #1's mouth. The SRNA stated she knew SRNA #1 would lose his job, but told SRNA #2 over three hours later they would have to report the incident. SRNA #3 stated she was aware she should have reported the incident immediately.</p>	F 225		
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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 41553
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F 225	<p>Continued From page 4</p> <p>Interview conducted with the Administrator on 03/04/15, at 10:10 AM, revealed she was notified on 02/19/15, at approximately 11:35 AM of the incident in which SRNA #1 placed a sock in Resident #1's mouth. The Administrator stated staff was required to report any incident or suspicion of abuse immediately. The Administrator stated SRNA #1 was terminated immediately, and SRNA #2 and SRNA #3 were both given disciplinary warnings because of their failure to immediately report the incident.</p> <p>2. Review of the medical record for Resident #2 revealed the facility admitted the resident on 12/04/12, with diagnoses that included Senile dementia, Depression, and Anxiety.</p> <p>Review of a quarterly MDS assessment for Resident #2 dated 12/10/14, revealed the resident had been assessed to have a BIMS score of 5, which indicated the resident was assessed to be severely cognitively impaired. The MDS also revealed Resident #2 required the extensive assistance of two persons for bed mobility and transfers.</p> <p>Review of a facility investigation dated 02/19/15, revealed Resident #2's family member called the facility and spoke with the Admissions Coordinator, and stated the resident told the family member that "people were in [his/her] room beating [him/her] and had [his/her] hands tied up." The facility completed an investigation on 02/19/15, and determined the incident was unsubstantiated. However, there was no evidence the facility notified state agencies of the incident.</p>	F 225		
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F 225	<p>Continued From page 5</p> <p>Review of a facility investigation dated 03/02/15, revealed Resident #2 alleged that a male staff member twisted the resident's arm. The facility investigated the allegation and determined it was unsubstantiated. However, there was no evidence the facility notified state agencies of the allegation.</p> <p>Interview conducted with the Admissions Coordinator on 03/04/15 at 10:00 AM, revealed she spoke with Resident #2's family member on 02/19/15 regarding allegations of abuse. The Admissions Coordinator stated she immediately notified the Administrator when she received the allegation.</p> <p>Interview conducted with the Administrator on 03/04/15, at 10:10 AM, revealed she was notified of the incident with Resident #2 on 02/19/15, and again on 03/02/15, and investigated the allegations. The Administrator stated the facility determined when Resident #2's family members do not visit frequently the resident had a tendency to make false allegations. The Administrator stated the state agencies were not notified because the allegations were unsubstantiated and the resident makes frequent untrue allegations. The Administrator further stated she should have reported the incidents to the state agencies.</p>	F 225			