STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185222	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Health and Rehabilitation	60 Phillips Branch Road Phelps, KY 41553

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 44974 Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure an alleged violation of an injury of unknown origin was immediately reported to the State Survey Agency (SSA) and to other officials (Adult Protective Services) in accordance with state law for one of three residents (Resident (R) 6) sampled for abuse. Specifically, the facility failed to report to the SSA and the Adult Protection Agency (Department for Community Based Services/DCBS) on 08/04/2024, when R6 was sent to the hospital for a suspected injury and it was discovered the resident had sustained a fracture to the left tibia which was of unknown origin. The findings include: Review of the facility's policy titled Abuse, Neglect and Exploitation, undated, revealed all allegations and/or suspicion of abuse (including injury of unknown origin) were required to be reported immediately to the Administrator, State Agency, Adult Protective Services and all other required agencies immediately, but not later than 2 hours after the event, if the event caused serious bodily injury. Review of R6's admission record revealed the facility admitted R6 on 01/19/2014 with diagnoses of cerebral palsy, other disorder of the bone, congenital deformities of the hip, and contractures of the bilateral hips and knees. Review of R6's Quarterly Minimum Data Set (MDS) with an Assessment Reference (ARD) date of 05/27/2024 revealed a Brief Interview for Mental Status (BIMS) was not conducted due to R6 was rarely/never understood. Review of the facility's investigation dated 08/04/2024, completed by the Administrator revealed, the Administrator had received a call from Licensed Practical Nurse (LPN) 3 who stated R6 was grabbing her leg (the resident) and making a hollering noise when she began to render care. Further review of the investigation revealed LPN3 contacted the Medical Director (MD) and received an order for R6 to be sent to hospital. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of the investigation, revealed the facility transferred R6 to the hospital and later received a call from the hospital staff informing LPN3 that R6 had an oblique displaced distal fracture of the left tibia. Further review revealed an investigation was immediately initiated and it was noted that R6 had no signs of pain on the morning of 08/04/2024 when assisted by staff into a Broda (a specialized reclining wheelchair) chair. Per the investigation, sometime before 2:00 PM when Certified Nurse Aide #5 (CNA5) went into the room, R6's roommate stated put the baby's foot up. Review of the investigation revealed R6's left leg was noted to be hanging off the side of the Broda chair. R6 and her roommate (R56) were sitting side by side and CNA5 picked up R6's leg to put it back on the Broda chair. Further review of the investigation revealed R6's roommate (who also had a diagnosis of cerebral palsy) was interviewed by the Administrator, and the roommate stated she had hurt R6's leg with her wheelchair. The facility's investigation concluded that the injury to R6's leg was caused by the roommate running into R6's leg with the her wheelchair. However, there was no documented evidence the facility reported the injury/fracture of R6's leg to the SSA or the Adult Protection Agency (Department for Community Based Services). Observation on 09/10/2024 at 11:52 AM of R6 revealed the resident was awake, alert and reclined in the Broda chair. An immobilizer boot was noted in place from the resident's left foot to her knee. An attempt to interview R6 was not successful as the resident made sounds, but did not vocalize any words. Further observation on 09/13/2024 at 11:35 AM revealed R6 was up in in the Broda chair. The resident was to her right side and an immobilizer boot was in place to the left foot and leg. The resident's hips and knees were noted to be in a contracted position. During an interview with the Administrator on 09/13/2024 at 3:55 PM, she stated she was notified on 08/04/2024 of a possible injury to R6's leg. She stated she began an investigation as soon she was made aware of the fracture to R6's leg. She stated there was no witness to the incident that occurred to R6's leg. Per the Administrator, she interviewed R6's roommate (R56) and R56 told her I hurt the baby. The Administrator stated R56 then started to cry. She stated on 08/04/2024, when the hospital notified the facility of the fracture to R6's leg, she determined the fracture occurred by R56 bumping R6 with her wheelchair. She stated she concluded this from R56's statement. She stated she was not aware of the increased frequency of R6's foot/leg falling off the Broda Chair. The Administrator stated she was aware of the reporting guidelines. Although, the Administrator stated the injury to R6's leg was of unknown origin when she began the investigation, she felt since she determined the cause of the injury quickly, that she did not need to report the injury to the State Survey Agency/Adult Protection.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44974 Based on observation, interview, record review, and policy review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for one of 22 sampled residents (Resident (R) 6). R6 utilized a Broda chair (a specialized reclining wheelchair) when out of bed. Staff interviews revealed the resident's foot would frequently fall off the edge of the Broda chair footrest. However, the facility failed to effectively address the positioning of the resident's foot/leg in the Broda chair. On 08/04/2024, the resident leg was bumped/hit by another resident's wheelchair, which resulted in a fracture to R6's left tibia. The findings include. Review of the facility's policy titled Accidents and Supervision, not dated revealed each resident would receive adequate supervision and assistive devices to prevent accidents. This included 1). Identifying hazards and risks. 2). Evaluating and analyzing hazards and risks. 3) Implementing interventions to reduce hazards and risks, and, 4). Monitoring for effectiveness and modifying interventions when necessary. Review of R6's record revealed the facility admitted R6 on 01/19/2014 with diagnoses of cerebral palsy, other disorder of the bone, congenital deformities of the hip, and contractures of the bilateral hips and knees. Review of R6's Quarterly Minimum Data Set (MDS) with an Assessment Reference (ARD) date of 05/27/2024 revealed a Brief Interview for Mental Status (BIMS) was not conducted because R6 was rarely/never understood. Per the MDS, R6 was dependent in all functional areas. Further review revealed the MDS did not list any assistive devices, although limitation in range of motion was coded as impaired on both sides. Observation on 09/10/2024 at 11:52 AM, of R6 revealed the resident was awake, alert and reclined in the Broda chair. An attempt to interview R6 was not successful as the resident made sounds, but did not vocalize any words. Further observation on 09/13/2024 at 11:35 AM revealed R6 was up in the Broda chair. The resident was to her right side and an immobilizer boot was in place to the left foot and leg up to her knee. The resident's hips and knees were noted to be in a contracted position. Review of R6's Comprehensive Care Plan (CCP) revealed a focus for self-care deficits in activities of daily living related to debility, weakness, cerebral palsy, severe intellectual disability, contractures, scoliosis, and congenital deformities initiated on 02/25/2021 and revised on 11/14/2022. The goal was that staff would ensure that R6 was dressed, groomed and odor free. This focus area was also revised on 06/14/2024. The interventions included: assess for need of positioning devices; assess/record/report to MD (medical doctor) signs of immobility complications, contractures, fall related injury, skin breakdown, mobility status changes and significant changes in condition; assist of two staff to transfer to Broda chair; assist to ensure adequate positioning while up in chair; and use pillows/positioning devices as needed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R6's late entry change in condition note dated 08/4/2024 at 4:29 PM revealed Licensed Practical Nurse (LPN) 3 notified by Certified Nurse Aide #1 (CNA1) that the nurse was needed in R6's room. CNA1 told the nurse that the resident was guarding left leg and not acting her normal self when touching left lower extremity. Upon assessment, the resident flinched when her left lower extremity was touched. Per the note, the physician was notified and new orders were received to send the resident to the hospital for treatment and evaluation of left leg pain. R6 had history of a left distal femur fracture and bone disorder. Review of the facility's investigation dated 08/04/2024, completed by the Administrator revealed she had received a call from Licensed Practical Nurse (LPN) 3 who stated R6 was grabbing her leg and making a hollering noise when she began to render care. Further review of the investigation revealed LPN3 had contacted the Medical Director and received an order for R6 to be sent to hospital. Per the investigation, R6 was sent to the hospital. Later the facility received a call from the hospital staff informing LPN3 that R6 had an oblique displaced distal fracture of the left tibia. Further review of the investigation revealed an investigation was immediately initiated and it was noted that R6 had no signs of pain on the morning of 08/04/2024 when assisted into a Broda chair. Per the investigation, sometime before 2:00 PM when CNA5 went into R6's room, the roommate stated put the baby's foot up. Continued review of the investigation revealed R6's left leg was noted to be hanging off the side of the Broda chair. R6 and her roommate were sitting side by side. CNA5 picked up R6's leg to put it back on the Broda chair. After positioning the resident's leg, R6 was observed to bite her own hand. Per the investigation, R6 bites her hands frequently and her hands stay wrapped to protect them. Further review of the investigation revealed R6's roommate (who also had a diagnosis of cerebral palsy) was interviewed by the Administrator, and the roommate (R56) stated she had hurt R6's leg with her wheelchair. The facility's investigation concluded that the injury to R6's leg was caused by the roommate running into R6's leg with her wheelchair. Review of R6's hospital discharge summary dated 08/07/2024 revealed the resident was admitted to the hospital on 08/04/2024 and discharged on [DATE] with a discharge diagnosis of Closed fracture of distal end of left tibia, unspecified fracture morphology. Per the summary, an orthopedic physician was consulted and non-operative management was recommended. Further review revealed recommendations for the resident to wear a fracture boot to the left lower extremity. Review of R56's admission record revealed the facility admitted the resident on 10/10/2020, with diagnoses of cerebral palsy, dementia, and depression. Review of R56's Quarterly MDS dated [DATE] revealed a BIMS score of three out of 15, which indicated R56 was severely cognitively impaired. Further review of the MDS revealed R56 was dependent with functional areas of transfer to wheelchair and required substantial assist with wheeling self. Attempted interview with R56 on 09/12/2024 at 9:00 AM was unsuccessful. The resident did not answer questions and kept asking the same question repeatedly. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During interview on 09/12/2024 at 9:15 AM with CNA5 she stated that she initially was not aware that R6's leg was injured on the morning of 08/04/2024. She stated R6 was already up to the chair when she started her shift at 7:00 AM and nothing was provided in report as to any significant change with R6. CNA5 stated she had gone into R6's room, not sure of the time, and the roommate (R56) stated fix baby's foot she stated R6's foot was hanging off the Broda chair and she picked up R6's foot and placed it back on the chair. She stated R6 bit her own hand at that time, but she didn't think much about it because this was normal behavior for R6. CNA5 stated R6's leg would frequently fall of the foot rest of the Broda chair. The CNA stated that both R6 and her roommate were in the middle of their room; R6 was in the Broda chair and R56 was in her wheelchair. She stated this was normal for the two residents as R56 would sit and hold R6's hand and call her baby. Later in the day when she and CNA1 went in the room to provide care they noticed R6 was not acting like herself and yelled out when her leg was touched. During an interview on 09/12/2024 at 2:10 PM with CNA1, he stated he had fed R6 breakfast on the morning of 08/04/2024 and had noticed she did not eat as well as she normally did. CNA1 stated around 2:00 PM during a check on R6 with CNA5, R6 kept grabbing his (CNA1) clothes, biting on her hand, and making noises. He stated LPN3 immediately contacted the resident's physician and R6 was sent to the emergency room (ER). CNA1 stated it was common for R6's foot to drop off the edge of the Broda chair due to R6 wiggling and sliding down in the chair. He stated R6 had to be pulled up and repositioned often during the shift. During an interview with CNA8 on 09/12/2024 at 3:06 PM, she stated she cared for R6 on 08/03/2024 on night shrift. She stated that on 08/03/2024 prior to 7:00 AM, R6 was her usual self, without signs or symptoms of distress or agitation, when she and CNA9 got R6 up to the Broda chair. CNA8 stated R6 needed frequent repositioning due to sliding down in the chair and her foot dropping off the edge of the Broda chair. During an interview on 09/13/2024 at 12:00 PM with CNA7 he stated he cared for R6 on 08/03/2024 and did not notice anything out of character with R6. He stated R6 needed special precautions and all resident care could be found on the Kardex. CNA7 stated R6's foot/leg fell off the edge of the Broda chair frequently. He stated he would always reposition and use pillows to attempt to prevent the resident's foot from falling but this would still occur. During an interview on 09/13/2024 1:15 PM with the Unit Manager Registered Nurse (RN) she stated she was aware that R6's foot/leg would drop of the edge of the Broda chair frequently. She stated staff were verbally told that R6 needed frequent repositioning and adjustments while up in a chair. The Unit Manager stated there was an order for R6 that staff may use pillows/wedges for positioning needs as needed. However, she stated she did not know if the resident's foot falling off the Broda chair was addressed on the care plan or Kardex. Per the Unit Manager, nurses were responsible for updating the care plan and the MDS coordinators added updates also. She stated she did not know if therapy had been contacted regarding possible adaptations to the Broda chair. Review of Therapy Notes revealed no documented evidence R6 had been evaluated for the problem of the resident's leg falling off the Broda chair's footrest. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 09/13/2024 at 1:25 PM with the Director of Nursing (DON) she stated she was aware that R6's foot/leg would slide off edge of the Broda chair. She further stated the staff would use pillows and wedge cushions to the left side frequently to reposition R6. The DON stated they had discussed in the interdisciplinary team (IDT) meetings ways to prevent this and positioning. She stated the care plan addressed the use for pillows and wedge cushions for repositioning as needed but the specific issue regarding R6's foot dropping off the chair was not addressed on the care plan, although all staff were made aware through report. She further stated that R6 was repositioned and readjusted frequently because R6 wiggles and slides down due to her contractures. She stated all staff knew to reposition R6 as needed. Further review of R6"s care plan and Kardex revealed that even though staff were aware of R6's foot frequently falling off the Broda chair prior to the incident on 08/04/2024, the facility had failed to address the problem in an attempt to prevent accidents. Additionally, after the incident on 08/04/2024, which resulted in the fracture to the resident's leg, the facility investigated the cause of the fracture but failed to identify the resident's foot falling off the chair or the resident's assistive device as being a potential accident hazard for the resident. During an interview on 09/13/2024 at 3:20 PM with the Director of Rehabilitation (DOR) she stated she was not aware of R6's foot/leg frequently dropping off the edge of the Broda chair. She stated that every resident had a therapy screening done which was not a hands-on evaluation but an observational screening to assess if any further needs were indicated for the resident. The DOR stated that during the screenings she had not observed R6's foot/leg dropping off the chair. She further stated the Broda chair was a standard made chair. The DOR stated she was not aware of adaptations or modifications that could be made to the Broda chair. Per the DOR, a different type of chair could possibly be looked at/used for the resident. During an interview on 09/13/2024 at 3:55 PM, the Administrator stated when she was contacted on 08/04/2024 regarding the information about R6 having an oblique fracture of the leg, an investigation was immediately initiated. She stated she interviewed R56 and R56 stated I hurt the baby and started to cry. The Administrator stated she was not aware of the frequency of R6's foot dropping off the Broda chair, but did know R6 required total care by staff. During an interview on 09/13/2024 at 4:00 PM, the Medical Director stated he had been immediately made aware of the incident with R6. He stated that R6 had osteopenic and osteoporotic bones that made her very susceptible to fractures. He stated he also suspected some type of other bone disorder, due to her diagnoses and her inability for weight bearing. The Medical Director stated that the oblique bone fracture correlated with the mechanism of injury (the foot/leg being caught/hit by another object). He stated he was part of the Interdisciplinary Team (IDT) and did make recommendations from a clinical standpoint. The Medical Director stated his expectation was for staff to follow those recommendations and follow the plan of care to ensure resident safety. He stated he did not recall discussing recommendations regarding this issue with R6 but he was knew his residents individually very well. However, he stated he was not specifically aware of the resident's foot falling off the foot rest of the Broda chair.