STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366236	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Village	422 North Burnett Road Springfield, OH 45503

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20298 Based on clinical record reviews, review of grievance forms, observations, staff interviews, review of two employee files, and policy review, the facility staff failed to implement their policy and provide appropriate and timely resolution to one resident's responsible family member's grievance concerning safe Hoyer transfers. This affected one (Resident #1) of five residents reviewed for grievances. The facility census was 61. Findings include: 1. Clinical record review for Resident #1 revealed an admitted [DATE] with diagnoses including stroke, diabetes, aphasia, anxiety, and bi-polar disorder. He received hospice services since 05/10/24. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition and could not respond or be interviewed. Review of the care plan revised 11/20/23 revealed the resident was at high risk for falls and required staff total assistance for all activities of daily living including Hoyer transfers. Review of the Concern/Grievance forms revealed on 03/11/24, Resident #1's daughter sent Social Service (SS) #80 a text message requesting a sign be posted in the room that two staff were to operate the Hoyer lift for transfers; the information was reported to the Director of Nursing (DON). On 03/25/24, Resident #1's daughter sent a video recording to SS #80 of evening shift (7:00 P.M. to 7:00 A.M.) staff using a Hoyer lift with one staff member to transfer Resident #1; the information was shared with the management team. On 04/01/24, Resident #1's daughter sent a second video to SS #80 of evening shift staff using a Hoyer lift alone to transfer the resident; the nursing department was notified. On 04/02/24, the DON documented on a Concern/Grievance form that she observed the video of State tested Nurse Aides (STNAs) using the Hoyer lift alone and spoke to Resident #1's daughter in the dining area. The DON would educate the staff and hang a sign in the room. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/09/24 at 1:10 P.M., the surveyor observed the two video recordings on SS #80's phone taken from a camera in Resident #1's room. The first recording received on 03/25/24 revealed the back of a dark skinned STNA transferring Resident #1 alone from his bed to his broda chair using a Hoyer lift. The second recording received on 04/01/24 revealed a different STNA wearing a mask transferring Resident #1 alone from his bed to his broda chair using a Hoyer life. At that time SS #80 verified she did not know the STNAs transferring the resident using a Hoyer lift alone. The surveyor observed the sign posted and signed by the DON in Resident #1's room that stated, Hoyers were to be used with two staff members. If I see or hear of staff using the Hoyer without assistants, I will terminate you no questions asked!!! Interview on 04/09/24 at 1:37 P.M. with the Administrator revealed he had not observed the two videos sent by Resident #1's daughter. He watched the two videos with the surveyor at that time and could not identify the two STNAs using the Hoyer alone. The surveyor showed the Administrator the sign the DON posted in Resident #1's room and he agreed the sign was inappropriate for any resident's room. He verified there were no resident accidents with the Hoyer lift. Interview on 04/09/24 at 2:30 P.M. revealed Human Resource #95 identified the two STNAs in the videos as night STNAs #100 and #104 after surveyor intervention. Interview with the DON on 04/10/24 at 9:45 A.M. revealed she did not observe videos until 04/02/24 and could not identify the STNAs in the video. The DON was informed the morning of 04/10/24 of who the two STNAs were in the videos and stated she would initiate an investigation. There was text training sent to all staff on 04/01/24 regarding the use of Hoyer's by two staff. She followed up with additional training for nursing staff on 04/02/24 and with the sign she posted in Resident #1's room regarding the Hoyer transfers with two staff only. The surveyor reviewed the employee files for two night shift STNA #104 hired 10/25/23 and STNA #100 hired 11/08/23. There was no evidence of counseling for the staff regarding improper Hoyer lift transfers. Interview with Human Resource Manager #95 on 04/10/24 at 1:15 P.M. verified there was no counseling in the employee files regarding the improper Hoyer lift transfers noted on the videos for STNAs #100 and #104. Review of the policy titled, Using a Mechanical Lift, dated July 2017 revealed at least two STNAs were needed to safely move a resident with a mechanical lift. Review of the policy titled, Response to Detected Issues and Remediation Policy and Procedure, dated 2022 revealed all suspected violations of compliance was investigated within a reasonable time. The investigation contained a description of the investigation, copies of interviews and key documents, a log of witnesses interviewed, the results of the investigation, any disciplinary action taken and the corrective action implemented. This deficiency was an incidental finding found during the course of the complaint investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for 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** 20298 Based on clinical record reviews, review of grievance forms, observations, staff and resident interviews, review of two employee files, and policy review, the facility staff failed to provide safe and appropriate lift transfers and failed to complete an investigation when staff transferred a resident alone with a Hoyer lift. This affected one (Resident #1) observed for safe Hoyer lift transfers. Additionally, the facility failed to provide adequate interventions and/or supervision to ensure a resident who was assessed as being at risk for elopements did not elope from the facility. This affected one (Resident #26) of one resident reviewed for elopements. The facility census was 61. Findings include: 1. Clinical record review for Resident #1 revealed an admitted [DATE] with diagnoses including stroke, diabetes, aphasia, anxiety, and bi-polar disorder. He received hospice services since 05/10/24. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition and could not respond or be interviewed. Review of the care plan revised 11/20/23 revealed the resident was at high risk for falls and required staff total assistance for all activities of daily living including Hoyer transfers. Review of the Concern/Grievance forms revealed on 03/11/24, Resident #1's daughter sent Social Service (SS) #80 a text message requesting a sign be posted in the room that two staff were to operate the Hoyer lift for transfers; the information was reported to the Director of Nursing (DON). On 03/25/24, Resident #1's daughter sent a video recording to SS #80 of evening shift (7:00 P.M. to 7:00 A.M.) staff using a Hoyer lift with one staff member to transfer Resident #1; the information was shared with the management team. On 04/01/24, Resident #1's daughter sent a second video to SS #80 of evening shift staff using a Hoyer lift alone to transfer the resident; the nursing department was notified. On 04/02/24, the DON documented on a Concern/Grievance form that she observed the video of State tested Nurse Aides (STNAs) using the Hoyer lift alone and spoke to Resident #1's daughter in the dining area. The DON would educate the staff and hang a sign in the room. On 04/09/24 at 1:10 P.M., the surveyor observed the two video recordings on SS #80's phone taken from a camera in Resident #1's room. The first recording received on 03/25/24 revealed the back of a dark skinned STNA transferring Resident #1 alone from his bed to his broda chair using a Hoyer lift. The second recording received on 04/01/24 revealed a different STNA wearing a mask transferring Resident #1 alone from his bed to his broda chair using a Hoyer life. At that time SS #80 verified she did not know the STNAs transferring the resident using a Hoyer lift alone. The surveyor observed the sign posted and signed by the DON in Resident #1's room that stated, Hoyers were to be used with two staff members. If I see or hear of staff using the Hoyer without assistants, I will terminate you no questions asked!!! Interview on 04/09/24 at 1:37 P.M. with the Administrator revealed he had not observed the two videos. He watched the two videos with the surveyor at that time and could not identify the two STNAs using the Hoyer alone. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/09/24 at 2:30 P.M. revealed Human Resource #95 identified the two STNAs in the videos as night STNAs #100 and #104 after surveyor intervention. Interview with the DON on 04/10/24 at 9:45 A.M. revealed she did not observe videos until 04/02/24 and could not identify the STNAs in the video. The DON was informed the morning of 04/10/24 who the two STNAs were in the videos and stated she would initiate an investigation. Review of the employee files for STNA #104, hired 10/25/23 and STNA #100, hired 11/08/23 revealed there was no evidence of counseling for the staff regarding improper Hoyer lift transfers. Interview with Human Resource Manager #95 on 04/10/24 at 1:15 P.M. verified there was no counseling in the employee files regarding the improper Hoyer lift transfers noted on the videos for STNAs #100 and #104. Review of the policy titled, Using a Mechanical Lift, dated July 2017 revealed at least two STNAs were needed to safely move a resident with a mechanical lift. 2. Clinical record review for Resident #26 revealed he was admitted on [DATE] with diagnoses including major depression, psychosis and adjustment disorder. Review of the resident's Minimum Data Assessment (MDS) dated [DATE] revealed he had intact cognition and was ambulatory. The resident had a court appointed guardian. Review of elopement assessments dated 01/09/24 and 03/25/24 revealed Resident #26 was a high elopement risk because he was capable of leaving, wandering, and had an elopement history. The interventions included using redirection techniques and alarmed/coded exit doors. Review of the resident's care plan revised 01/25/23 revealed he was at high risk for elopement with a history of elopement attempts and impaired safety awareness. Interventions for when the resident attempted to leave the building unattended included providing activities that distracted him from wandering. Review of a late entry progress note dated 04/10/24 revealed on 03/25/24 at 9:30 A.M. Resident #26 could not be found in the facility or vicinity. The resident's guardian, physician, and police were notified he was missing. On 03/25/24 at 11:30 P.M. the note revealed the resident returned to the facility, refused a skin assessment, and one to one supervision was provided until further notice. The resident had no injuries. Interview with Resident #26 on 04/10/24 at 1:50 P.M. revealed he, just walked out because he was held here illegally when the surveyor asked him how he exited the facility on 03/25/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 04/10/24 at 2:00 P.M. revealed they were considering Resident #26's missing from the facility as an unauthorized leave of absence because his guardian did not want him leaving unattended. On 03/25/24, the resident was last seen at 8:00 A.M. that morning and was returned by the police at 6:30 P.M. with no injuries. They had a soft file that outlined staff searching areas of town starting at 9:30 A.M. that morning until his return at 6:30 P.M The Administrator did not provide the surveyor with any additional documented investigation of how the resident exited the facility. He stated the resident did not appear on camera leaving any of the exits including the courtyard. There were no clues when staffed checked the windows; however, they concluded the resident must have gone out a window. Since his return on 03/25/24 the resident had one to one staff supervision to prevent further elopements until he could be evaluated by a psychiatrist. Review of the policy titled, Wandering and Elopements, dated March 2019 revealed the staff identified residents at risk for unsafe wandering and strived to prevent harm. If a resident eloped, the Director of Nursing (DON) completed an incident report and documented relevant information in the medical record. This deficiency represents non-compliance investigated under Complaint Number OH00152538.