STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365093	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd The	622 Center St Ashland, OH 44805

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on staff interview and record review, the facility failed to ensure Notice of Medicare Non-Coverage (NOMNC) and Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) forms contained all the necessary information. This affected one (#65) of three residents reviewed for beneficiary notices. The facility census was 119. Findings include: Review of Resident #65's medical record revealed an admitted [DATE]. Medical diagnoses included cerebrovascular accident (stroke), dementia, type II diabetes mellitus with diabetic neuropathy and a history of falls. Review of the Notice of Medicare Non-Coverage (NOMNC) provided to Resident #65's representative, dated 02/19/24, revealed the resident's skilled services would be ending on 02/21/24. The NOMNC did not list what specific type of skilled service would be ending. Review of the SNF ABN provided to Resident #65's representative, dated 02/19/24, revealed the resident's skilled services were being discontinued as the resident no longer required skilled services. The noticed contained no specific information as to what skilled service was being discontinued, and what specific cost the resident would incur if they desired for skilled services to continue. The cost section of the notice was labeled for the semi-private room and board rate of $304 per day. Interview on 07/18/24 at 9:25 A.M. with Director of Social Services and Admissions #605 confirmed the NOMNC and SNF ABN forms were completed incorrectly for Resident #65. The NOMNC did not contained the specific skilled service that was ending. The SNF ABN form contained only the facility's semi-private room and board rate and contained no details on what skilled services was ending, and what the cost would be for the resident to continue receiving skilled services.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49794 Based on observation, medical record review, and staff interview, the facility failed to implement a splinting program to prevent further decrease in range of motion (ROM). This affected one (#23) of one resident reviewed for ROM. The facility census was 119. Findings include: Review of the medical record for Resident #23 revealed and admitted [DATE]. Diagnoses include aphasia, metabolic encephalopathy, contracture of the muscle of multiple sites, unspecified epilepticus, and contracture the right hand. Review of an annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 had severe cognitive impairment and was fully dependent on staff for toileting, eating, and transferring. Review of a therapy note dated 11/30/23 revealed Resident #23 was to have a rolled splint applied to the right hand and a resting splint should be used for the left hand to promote digit extension. The therapy note revealed pictures were printed and instructions were provided for staff. Review of nurse aide documentation revealed Resident #23 was to wear bilateral hand splints one at a time for two hours each alternating for eight hours upon waking. Further review of July 2024 splint nurse aide task documentation for Resident #23 revealed splints were applied on the resident's hands on 07/02/24, 07/04/24, 07/05/24, 07/08/24, 07/09/24. 07/11/24, and 07/12/24. Resident #23 did not have splints applied on 07/01/24, 07/03/24, 07/06/24, 07/07/24, 07/10/24, 07/13/24, 07/14/24, 07/15/24, and 07/16/24. Observation on 07/15/24 at 9:12 A.M., 07/16/24 at 1:34 P.M., 07/17/24 at 9:57 A.M., 07/17/24 at 2:30 P.M., 07/17/24 at 4:26 P.M., and 07/18/24 at 8:46 A.M. of Resident #23 revealed splints were not in place on the left or the right hand. Interview on 07/17/24 at 2:42 P.M. with State tested Nurse Aide (STNA) #400 confirmed splints were not on either of Resident #23's hands. STNA #400 stated Resident #23 had an order to use blocks with the resident's hands at one time but thought they did away with using blocks two months ago and was not aware of any interventions currently being used. Interview on 07/18/24 at 8:48 A.M. with Licensed Practical Nurse (LPN) #517 confirmed Resident #23 should be wearing splints to her hands but splints were not in place.

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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** 47990 Based on observation, staff interview, medical record review, policy review, and review of facility incident reports, the facility failed to ensure fall interventions were appropriate and resident-centered, and failed to ensure residents with Wander-guards had current physician orders for the security devices. This affected two (#65 and #45) of six residents reviewed for accidents. The facility census was 119. Findings include: 1. Review of Resident #65's medical record revealed an admitted [DATE]. Medical diagnoses included cerebrovascular accident (stroke), dementia, type II diabetes mellitus with diabetic neuropathy, and a history of falls Review of Resident #65's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed with severely impaired cognition. The resident had no recorded behaviors or rejection of care. The resident was identified to have two or more falls without injury and one fall with a minor injury since the prior assessment. Resident #65 was required supervision with eating, substantial/maximum assistance with activities of daily living, and required partial/moderate assistance with mobility and transfers. Review of Resident #65's plan of care dated [DATE] revealed the resident had potential for falls related to a new environment and a decline in condition. Interventions implemented included to encourage and assist with wearing non-skid footwear at all times, monitor and notify the nurse of confusion and anxiety, place frequently used items within reach, and to utilize a personal sensor alarm to bed and chair per family request to assist with safety and fall prevention. Review of Resident #65's medical record revealed she sustained falls on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Review of Resident #65's fall risk assessment, dated [DATE], revealed the resident was identified to be at moderate risk for falls. Review of the facility-initiated incident reports for Resident #65 revealed on [DATE] Resident #65 sustained a fall from the wheelchair while seated in a common area near the nurse's station. The report indicated the resident was alert only to person and place and had impaired memory. The report described Resident #65 as forgetful and unable to remember that she cannot walk. A summary note of the fall, dated [DATE], revealed the intervention for Resident #65's fall dated [DATE] was to re-educate the resident on asking for assistance with transfers. Review of an incident report dated [DATE] revealed Resident #65 sustained a fall after she was observed on the bathroom floor. The report indicated the resident was oriented to person and place. The report recorded Resident #65 as being confused and with impaired memory. A summary note of the fall, dated [DATE], revealed the intervention for Resident #65's fall dated [DATE] was to re-educate the resident against self-transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the incident report dated [DATE] revealed Resident #65 sustained a fall and was observed on the floor with the alarm sounding. The report indicated the resident was alert and non-compliant. A summary note of the fall, dated [DATE], revealed the resident was alert to person and place. The note indicated the resident had poor safety awareness and the listed intervention for the fall on [DATE] was to re-educate the resident on call light usage for assistance. Review of the incident report dated [DATE] revealed Resident #65 sustained a fall in her room. The report indicated Resident #65 was oriented only to person, was confused, and had impaired memory. A summary note of the fall, dated [DATE], revealed the resident was alert and oriented to person and place with poor safety awareness. The listed intervention for the fall dated [DATE] was listed as re-educating the resident and a therapy screening was requested. Review of the incident report dated [DATE] revealed Resident #65 sustained a fall in her room. Resident #65 was listed as oriented only to person, with confusion, and had impaired memory. A summary note of the fall, dated [DATE], revealed the listed intervention for the [DATE] fall was listed to continue to re-educate the resident. Review of the incident report dated [DATE] revealed Resident #65 sustained a fall in her room. The resident was listed as only oriented to person, with confusion, and had impaired memory. A summary note of the fall, dated [DATE], revealed a room change was completed to move Resident #65 closer to the nurse's station. Review of the incident report dated [DATE] revealed Resident #65 sustained a fall in her room. The resident was attempting to re-arrange furniture in her room and fell . The resident was listed as only oriented to person, with confusion, and had impaired memory. There was no included summary note and no listed intervention to prevent further occurrences. An observation on [DATE] at 12:50 P.M. revealed Resident #65 was seated in her wheelchair in the common area. The resident had a personal alarm to her wheelchair in place and in the on position. An interview was attempted with Resident #65 and was unsuccessful due to the resident's cognition. Interview on [DATE] at 1:16 P.M. with Assistant Director of Nursing (ADON) #427 stated she does not attend the weekly fall meeting, but other members of nursing leadership attend and review falls to ensure appropriate interventions were in place. ADON #427 confirmed it was the facility's practice to implement interventions after instances of falls. Interview on [DATE] at 9:05 A.M. with Staff Development Nurse #478 revealed she oversaw and tracked falls at the facility. Staff Development Nurse #478 stated falls are reviewed weekly with the fall committee, and interventions are placed following instances of fall. Interview on [DATE] at 9:05 A.M. with the Director of Nursing (DON) verified Resident #65 was severely cognitively impaired. The DON verified the fall interventions placed following instances the resident's falls of education and re-education were inappropriate and ineffective due to the resident's cognition. Review of the fall policy dated [DATE] revealed the use of specific interventions to try and reduce a resident's risks from hazards in the environment. The process includes documenting interventions and ensuring the interventions are put in place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #45's medical record identified admission to the facility occurred on [DATE] with medical diagnosis including dementia, weakness, and pneumonia. Review of an elopement risk assessment dated [DATE] revealed Resident #45 was identified by the facility to be a moderate risk for elopement. The record identified no physician orders for a Wander-guard. Resident #45's most recent admission MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired. Observation of Resident #45 on [DATE] at 7:16 A.M. and [DATE] at 12:29 P. M. revealed the resident was observed with the Wander-guard device on her right ankle. Interview with Registered Nurse (RN) #500 on [DATE] at 8:34 A.M. confirmed Resident #45 had a Wander-guard on her right ankle and had physician's order for the device. Review of the Wander Management policy, updated [DATE], identified the purpose was to establish a means of prevention for elopement. The policy revealed a wander system equipped with door alarms is in place to alert staff to a resident leaving the facility unassisted. In the event the alarm system fails and or a resident is able to circumvent the system and their location cannot be determined, the facility shall take immediate action to locate the resident. The wander system bracelets will be checked each shift to ensure they are still in working order and not expired. The policy identified an assessment of residents will occur upon admission, after changes in condition, and at regular intervals thereafter. The nursing and social services departments will identify residents at risk for wandering and seek physician orders for security alarm ankle bracelets. The policy identified the process if a resident is determined to be at risk for elopement and an order will be obtained for a wander management bracelet to to applied. 34298 16453

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990 Based on observation, staff and resident interview, medical record review, and policy review, the facility failed to ensure residents who required non-invasive mechanical ventilation through the use of a continuous positive airway pressure (CPAP) machine had a physician order in place with specified settings for the machine. This affected two (#09 and #59) of two residents reviewed for respiratory care. The facility census was 119. Findings include: 1. Review of Resident #09's medical record revealed an admitted [DATE]. Medical diagnoses included asthma, chronic obstructive pulmonary disease (COPD), and morbid obesity. Review of Resident #09's Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed the resident had severely impaired cognition and had no recorded behaviors or rejection of care. Review of Resident #09's physician order dated 01/04/23 revealed the resident was to have a CPAP machine that was to be applied per home settings nightly at bedtime and as needed. The order did not include detailed settings. Review of Resident #09's treatment administration record for April, May, and July 2024 through 07/17/24 revealed the resident was recorded to have used the CPAP on a nightly basis. Observation on 07/16/24 at 6:42 A.M. revealed Resident #09 was lying in bed. The resident had a facial mask in place and was connected to her CPAP machine. There were no clearly visible settings on the machine. Interview on 07/16/24 at 6:46 A.M. with Licensed Practical Nurse (LPN) #474 revealed the facility had on-site respiratory therapists who would clarify any orders and program equipment to the ordered settings. LPN #474 confirmed the staff nurses do not set or program respiratory equipment. LPN #474 verified she was unsure what the resident's ordered CPAP settings were, but stated she could check the orders. LPN #474 checked the residents orders and confirmed the order only specified CPAP per home settings. LPN #474 confirmed she had no way to verify if the CPAP was on the correct setting. Interview on 07/17/24 at 6:41 A.M. with Registered Nurse (RN) Supervisor #496 revealed residents with CPAP machines were supposed to have orders and settings in their respective physician's orders. RN Supervisor #496 explained the respiratory therapy department assisted with clarifying respiratory-related orders. Interview on 07/17/24 at 6:51 A.M. with Respiratory Therapist (RT) #575 revealed the respiratory therapy department assisted in clarifying respiratory-related orders if needed. RT #575 confirmed settings should be in the provider's orders for all respiratory devices, including CPAP machines. Interview on 07/18/24 at 6:41 A.M. with the Director of Nursing (DON) confirmed Resident #09's CPAP order did not contain settings. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #59's medical record identified admission to the facility occurred on 08/31/20 with medical diagnosis including sleep apnea, heart failure, anxiety, and bipolar disorder. Review of Resident #59's physician orders for July 2024 identified no evidence of any CPAP orders. Observation of Resident #59 occurred on 07/16/24 at 8:57 A.M. Resident #59 was in bed and was observed to have his CPAP machine on and running. Interview with Resident #59 on 07/16/24 at 12:49 P.M. confirmed he has been using the CPAP machine for a long time and someone came in weekly to service the machine. Interview with the Director of Nursing (DON) on 07/17/24 at 1:55 P.M. confirmed Resident #59 did not have any physician orders or evidence of tubing changes in his medical record, even though the tubing is dated as being changed. The DON confirmed the facility policy did contain the need for physician orders and documented servicing of the CPAP machine. Review of the facility noninvasive ventilation (CPAP) policy dated 06/12/23 revealed it was the policy of the facility to provide noninvasive ventilation as per physician's orders and current standards of practice. The facility will obtain an order for the use of the CPAP and settings from the practitioner. Staff are to document the use of the machine, resident tolerance, and any skin respiratory or other changes and responses. 16453

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on medical record review, resident interview, and staff interview, the facility failed to provide dental care in a timely manner. This affected one (#28) of one residents reviewed for dental care. The facility census was 119. Findings include: Review of the medical record revealed Resident #28 was admitted on [DATE] with diagnoses that included type II diabetes, anxiety, and dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 was cognitively intact. Review of a dental note dated 03/15/24 revealed Resident #28 had the potential need for a consultation with an oral maxillofacial surgeon. Resident #28 potentially had extractions that were surgical in nature. Resident #28 had ankylosed (fusion between tooth/teeth and underlying bony support tissues) teeth that would need to be surgically removed by an oral surgeon. Resident #28 was ordered Peridex (used to treat gum inflammation) twice a day for seven days and amoxicillin (antibiotic) 500 milligrams every six hours. A health status note dated 03/15/24 at 2:30 P.M. revealed Resident #28 was seen by the facility dentist for a tooth extraction. The dentist was unable to pull Resident #28's tooth and was to be referred to an oral surgeon. Review of a dental note dated 06/17/24 revealed the dentist was not present and Resident #28 was seen by the dental hygienist for dental prophylaxes and topical fluoride. Resident #28 had issues with two teeth which were mobile and had a treatment for one of them to be removed. Interview on 07/16/24 at 9:00 A.M. with Resident #28 stated the resident needed to see the dentist because of a loose tooth. Interview on 07/18/24 at 9:32 A.M. with the Director of Nursing (DON) revealed there had been communication with an oral surgeon, but the oral surgeon could not pull Resident #28's tooth until 2025. The DON verified there was no documentation of the oral surgeon being contacted.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34298 Based on observation, staff interview, medical record review, and policy review, the facility failed to use the proper cleaning chemicals were utilized in a resident room with isolation precautions. This affected one (#365) of one residents in contact isolation. The facility census was 119. Findings include: Review of the medical record revealed Resident #365 was admitted on [DATE] with diagnoses that included cellulitis of the left lower leg, Clostridium difficile (C. diff), and dementia. Review of the plan of care dated 07/15/24 revealed Resident #365 had an infection and had the potential for complications related to infection and the treatment of infection. Resident #365 was on the antibiotic vancomycin for C. diff until 07/21/24. Interventions included to administer medications as ordered and use the appropriate precautions. Observation on 07/16/24 at 12:47 P.M. revealed Resident #365 was sitting on the side of the bed and Housekeeper #556 was mopping the floor in Resident #365's room. Interview on 07/16/24 at 12:49 P.M. with Housekeeper #557 revealed the mop water had chemicals in it filled the mop bucket with the chemicals located on the wall in the housekeeping room. Housekeeper #557 stated she thought the chemicals would kill C. diff bacteria because the chemical killed everything. Interview with Housekeeping and Laundry Manager (HLM) #447 on 07/17/24 at 12:26 P.M. revealed housekeepers were aware of why residents were on contact isolation precautions so the proper chemicals could be used to clean the room. Observation on 07/17/24 at 12:29 P.M. of chemicals located on the wall in the housekeeping room revealed the chemical was called BNC-15 and was a multi-purpose cleaner. Review of the label for BNC-15 revealed it was a one-step disinfectant, cleaner, sanitizer, fungicide, mildewstat, and virucide. HLM #447 verified BNC-15 did not list it was effective in killing C. diff bacteria, and verified another chemical was to be used if contact isolation was due to C. diff. Review of the policy and procedure for C. diff revised on 03/14/17 revealed the disinfectant must be a environmental protection agency (EPA) registered, hypochlorite-based (bleach based), and directions will be followed as per label for drying and kill time. Review of the policy and procedure for daily cleaning of isolation rooms revised on 02/20/19 revealed housekeeping will use approved environmental cleaners and follow directions provided by the manufacturer. All C. diff rooms will be cleaned with bleach-based products.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 49794 Based on infection control tracking, staff interview, and policy review, the facility failed to follow antibiotic stewardship practices in prescribing antimicrobials. This affected 17 (Resident #6, #7, #9, #21, #27, #40, #51, #55, #69, #57, #70, #73, #76, #78, #83, #101, and #107) of 57 resident entries for antimicrobial treatments initiated in May and June 2024. The facility census was 119. Findings include: Review of infection control tracking for May 2024 revealed there were 32 antimicrobial (antibiotic and antifungal) treatments tracked for the month. The treatments were prescribed from a variety of sources that include from the hospital upon admission, emergency room prescribers, hospice prescribers, and the facility's prescribers. Of the antimicrobial treatments tracked in May 2024, 21 were prescribed by the facility's prescribers. Of the antimicrobial treatments prescribed by the facility's prescribers in May 2024, nine did not meet criteria for use and the antimicrobial was not discontinued. Review of infection control tracking for June 2024 revealed there were 25 total antimicrobial treatments tracked for the month. The treatments were prescribed from a variety of sources that include from the hospital upon admission, emergency room prescribers, hospice prescribers, and the facility's prescribers. Of the antimicrobial treatments tracked in June 2024, 13 were prescribed by the facility's prescribers. Of the antimicrobial treatments prescribed by the facility's prescribers in June 2024, 11 did not meet criteria for use and antimicrobial was not discontinued. Interview on 07/018/24 at 01:00 PM with Assistant Director of Nursing (ADON) #427 confirmed facility used McGeer's criteria to determine the existence of an infection and need for antimicrobial treatment. ADON #427 confirmed 11 residents did not meet the criteria for treatment in June 2024 and nine did not meet the criteria for antimicrobial treatment in May 2024, but antimicrobial treatments were not discontinued. ADON #427 confirmed the facility did not do an antibiotic timeout within 48 to 72 hours of initiation of the antibiotics to review for appropriateness. Review of the antibiotic stewardship policy dated 04/03/17, and revised 12/05/23, revealed the Medical Director oversees adherence to antibiotic prescribing practices, and reviews antibiotic use data and ensures best practices are followed. The policy revealed the facility uses the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) surveillance definitions, updated McGeer criteria, or other surveillance definitions to define infections and the Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics. The policy further revealed that nursing will conduct an antibiotic timeout within 48 to 72 hours of antibiotic therapy to review laboratory results and consult with the practitioner to determine if the antibiotic is to continue or if adjustments need to be made based on findings.