STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165072	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Health Center	302 Second Street NE Mason City, IA 50401

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 25854 Based on observation, family interview and review of the Resident Rights the facility staff failed to treat a resident with dignity and respect while providing cares and treatment while speaking with the resident and/or the family member present at bedside for 1 of 3 residents reviewed (Resident #4). The facility reported a census of 165 residents. Findings include. On 8/23/24 at 11:53 AM observed the call light monitor and clock at the nurse's station. At that time, noted Resident #4's call light on for 16 minutes. At 11:54 AM Staff G, Licensed Practical Nurse (LPN), entered the room. Staff G brought in a nutritional drink and Resident #4's pain patch. Staff G became defensive when she spoke with Resident #4 and his daughter. She spoke in a derogatory tone, rolled her eyes, and made negative facial expressions. Resident #4's family member (RR #4) asked if the surveyor saw that and reported Staff G always addressed her mother and/or herself that way. The facility provided Resident Rights form dated October 2017 directed the facility to treat each resident with respect and dignity. In addition, the facility must care for each resident in a manner and environment, that promoted maintenance or enhancement of their quality of life, along with recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The Registered Nurse/LPN job description reviewed 9/1/21 under Other Qualifications directed the nurse understood the need to present self at work with a good attitude.

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25854 Based on observation, clinical record review, facility policy review, family, physician, emergency medical personnel, and staff interview, the facility failed to implement interventions in a timely manner for a resident following a fall for 1 of 3 residents reviewed (Resident #3). The facility failed to intervene after Resident #3 fell and complained instantly of new pain to his ribs. Despite, the family's frequent questioning about Resident #3's situation, the facility failed to send him to the hospital for 2 hours and 36 minutes following his fall. The facility's policy requires someone from nursing management to assess a resident following an incident. It took the nursing supervisor approximately 1 hours after Resident #3 fell for the nursing supervisor assessed Resident #3. Following the nursing supervisor's assessment requested by Resident #3's family, the nursing supervisor attempted to contact the physician for an order to send him to the hospital. Resident #3 transferred to the hospital approximately 2 hours and 36 minutes following his fall, and approximately 1 hour after the nursing supervisor determined to send him. Once Resident #3 arrived at the emergency room , the staff found he suffered from a punctured lung, multiple rib fractures, and injuries inconsistent with the reported fall. Once at the hospital, the staff intubated Resident #3 and admitted him to the intensive care unit (ICU). After the hospital staff determined the extent of Resident #3's injuries and visited with his family. At that time, the decided to remove the intubation and transition to comfort measures on hospice on 8/15/24. The hospital records indicated Resident #3 passed away on 8/17/24. The delay in treatment for Resident #3 resulted in an immediate jeopardy situation. The facility identified a census of 165 residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) on August 23, 2024 that began as of August 13, 2024. The Facility Staff removed the Immediate Jeopardy on August 23, 2024 through the following actions: a. Revised post-incident protocol to include the following provisions to all nursing staff that in the instance of a suspected injury or change of condition: i. If the house supervisor is not available the charge nurse can and should contact emergency personnel and arrange transportation to the emergency department (ED) if the situation is deemed emergent or urgent. ii. If the physician does not respond within 60 minutes to a phone call to request to transfer to ED, that the supervisor or designee should call emergency response and arrange for transport. This should be followed with continued efforts to contact the physician to notify of the transfer. iii. Should include a review of resident's medications to determine what factors those medications could potentially have upon the assessment of the resident and potential outcomes. b. The facility provided immediate reeducation to House Supervisors and charge nurses to include the above. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Summary will be placed on the electronic communication board on 8/23/24 for all clinical staff to read. d. The facility placed the policy at each nurses' station on 8/23/24 for staff signature. The facility tracked the signatures against their staff roster to ensure all nurses received the education prior to their next shift. e. New staff, agency, and contract staff orientation will include the revised policy prior to their first shift. The scope lowered from a J to G at the time of the survey after ensuring the facility implemented education and their policy and procedures. The facility identified a census of 165 residents. Findings include: Resident #3's Minimum Data Set (MDS) assessment dated [DATE] indicated he had highly impaired vision. The MDS identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. Resident #3 required substantial to maximum assistance from staff with sit to stand transfers and partial to moderate assistance from staff with ambulation. The MDS included diagnoses of a wedge compression fracture of lumbar vertebra (the front of the vertebral body collapses but the back portion did not), age-related osteoporosis, low back pain, muscle weakness, spinal stenosis (spaces inside the bones of the spine became too small) in the lumbosacral (mid to lower back) region, primary osteoarthritis, and diabetes mellitus (DM). The assessment reflected Resident #3 had occasional pain with the highest rating of a 5 on a scale of 0-10 (10 being the highest amount of pain) which occasionally interfered with his day-to-day activities. Resident #3 took as needed (PRN) pain medication in the lookback period. The Care Plan included the following Focus areas: a. 4/11/24: An activities of daily living (ADL) self-care performance deficit related to (r/t) low back pain and essential tremors. The interventions directed: i. Dependent ambulation assistance from 2 staff members, gait belt (GB) and front wheel walker (FWW) with a wheel chair (w/c) to follow. Dated 4/10/24 and revised 6/20/24. ii. Partial/moderate transfer assistance from 1 staff member with a GB and FWW, may use 2 staff members PRN. Initiated 4/10/24 and revised 6/20/24). b. A Pacemaker (device that sent electrical pulses to the heart for maintenance of a normal heart rate and rhythm). Initiated and revised 4/10/24. c. High risk for falls r/t low back pain r/t age related osteoporosis with a current pathological fracture (bone fracture caused by weakness of the bone structure) of the vertebrae and meniere's disease. Initiated 4/10/24 and revised 4/16/24. The Interventions directed Resident #3 required prompt response to all requests for assistance. Initiated 4/10/24. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. Chronic pain r/t lumbar (lower back) compression fractures, spinal stenosis of the cervical and lumbar regions. Resident #3 used PRN pain medication. Initiated 4/10/24 and revised 6/4/24. e. Impaired visual function r/t Glaucoma (increased pressure in the eyes that affects vision). Initiated 4/10/24. The Fall Risk Evaluation dated 7/16/24 reflected a score of 11, identifying Resident #3 at risk for falls. Resident #3's August 2024 Medication Administration Record (MAR) reflected he received the following Physician orders: a. Oxycodone 5 milligram (mg) tablet one (1) by mouth (po) every six (6) hours PRN for pain dated 6/19/24 at 11 PM. i. Documentation on 8/1/24, 8/2/24 and 8/4/24 thru 8/12/24 indicated he received a dose, due to a pain range of 2 to 5. ii. Documentation reflected he received a dose on 8/13/24 at 6:33 PM for pain rated at a 7, indicating a moderate amount of pain. b. Isosorbide Mononitrate (medication used to dilate the vessels, making blood flow easier) tablet 60 mg extended release (ER) 1 tablet once a day in the morning (AM) for hypertension (HTN - high blood pressure), atherosclerotic heart disease of the coronary artery with angina pectoris (a form of heart disease that can cause pain) dated 4.9.24 at 11 PM. Give in the morning (AM). c. Losartan Potassium tablet 25 MG tablet by mouth (po) every 12 hours for HTN dated 4.9.24 at 11 PM. Give at 8 AM and 8 PM The Fall with Injury report dated 8/13/24 at 5:15 PM identified as the certified nurse aides (CNA's) walked down the hall to help the residents to dinner, they found Resident #3 lying on the floor as his wife asked for help. The CNA's alerted the Registered Nurse (RN) of Resident #3 fell . Resident #3 had a pillow under his head with his wheelchair positioned in front of the recliner and his walker on its side. Resident #3 complained of rib pain when he moved his shoulder joint, but had no change in his level of consciousness (LOC). The staff noted a pink mark on his left torso from the arm of the wheel chair (w/c). The staff applied a gait belt (GB) assistive device and with the assistance of 2 staff, they helped him stand and positioned him into his w/c. Resident #3's left-hand sustained skin tears across his knuckles as well as his left upper forearms. The nurse cleansed the skin tears, rolled the skin over the open areas, and applied steri strips. Then the nurse covered the area with a non adherent pad (dressing that shouldn't stick) to the left forearm and wrapped with a kling wrap (type of gauze wrap). At 5:55 PM Resident #3's spouse returned from dinner and asked him if he felt hungry. At which time he responded yes and wished to go to dinner. Resident #3 used the urinal independently, coached to cough, respirations even, and non labored at 20-22 breaths per minute. He complained of discomfort during the cough and deep breathing requests. As Resident #3 transferred himself from the recliner to the w/c with the use of a walker, he remembered the w/c had the brakes locked. As he turned and sat down in the w/c the spouse attempted to help him. She moved the w/c, this resulted in him missing the w/c. He fell , striking his left torso and right axilla. The Injuries Observed at Time of Incident section indicated he had no injuries at the time of incident. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/22/24 at 12:22 PM Staff A, CNA, indicated around 5:00 to 5:10 PM, as she walked back from the dining room, she heard Resident #3's wife scream for help. When she entered their room, she observed Resident #3 positioned on the floor in front of the recliner, on his back, with his head under the desk area. Resident #3's wife already placed a pillow under his head. Staff A observed Resident #3's w/c shoved into the recliner and the walker right beside him in a standing position but they didn't know if the wife sat it up post fall or not. (Resident #3's wife had a BIMS score of 7, indicating severely impaired cognition). Resident #3 reported his ribs hurt, Staff A described this as a new complaint because he only complained of back pain. At that time, he called out to get him off the floor a couple times. The charge nurse arrived and assessed Resident #3, however she didn't know for sure if the nurse performed range of motion. The nurse then made the call to stand him. The nurse positioned herself on 1 side, a certified medication aide (CMA) on other as Staff A stood at his back side, while another unknown staff member maneuvered the w/c. When the staff stood him, Staff A said she wanted to say yes, he cried out in pain. The staff positioned him in his w/c until around 7 PM when he wanted to get in his recliner. The staff decided to use a lift device for the transfer process and for provision of more support for the resident. When the staff moved him forward in the w/c for placement of the sling device the resident made an ugg sound. The staff transferred Resident #3 with the lift device and positioned him in his recliner, where he appeared content after they got him situated. Staff A indicated around 8 PM she walked around the corner of the hallway and observed the Emergency Medical Service (EMS) as they arrived approximately 3 hours after his fall. The staff member stated, I wished they would have sent the resident out right way. During an interview on 8/22/24 at 12:36 PM Staff B, Registered Nurse, (RN) indicated at the time of Resident #3's fall, she performed blood sugar checks on a couple residents and gave insulin as the 2 aides who worked her area assisted other residents to the dining room. A little after 5:00ish PM Resident #3's wife stopped 1 CNA in the hall. One of the staff members reported to Staff B that Resident #3 fell . When Staff A responded, she found him on his back in his room with a pillow under his head as he complained of pain to the left side of his ribs. As Staff B assessed Resident #3, she noted him upset as he pointed at his wife and yelled she moved his w/c. The staff members placed a GB and noted a red mark that resembled the arm of the w/c on Resident #3's left side. The staff stood on each side of Resident #3 while 1 stood to his back and got him up and positioned him in the w/c. Resident #3 presented as real upset with his wife, so Staff B asked her if she wanted to go to dinner and she agreed. Staff B said she saw Resident #3's w/c brakes locked at that time. Staff B described Resident #3's vitals as stable and he never complained of shortness of breath (SOB) rather he just complained of his ribs hurting. Staff B reported she failed to assess Resident #3's lung sounds. Staff B indicated she got everything checked out and asked what happened. Resident #3 stated he sat in his recliner and he had his w/c positioned in front of him. As he stood up his wife moved his w/c to what she felt a better position and as he sat down his left axilla (arm pit) got caught on the arm rest and he just sat down on the floor. The arm of the w/c would have been the level of his arm. As Resident #3 sat in the w/c he still complained of of rib pain. Staff B contacted Staff E, RN/House day Supervisor, on the day shift at approximately 5:30 PM or within 10 minutes. Staff E indicated she didn't know when she could get down there, so Staff B stayed with Resident #3 until around 6 PM when his wife returned to the room. At that time, she felt comfortable enough to leave him alone. Staff B indicated she felt she needed to stay with Resident #3 until Staff E arrived and/or when she felt he had been safe. Staff B indicated she called the house supervisor again. At that time Staff D, RN/house night supervisor, came down to Resident #3's room right way and he assessed him. Following the assessment, Staff D felt Resident #3's situation didn't warrant a hospitalization , although she wasn't present during the assessment. Staff B indicated the decision to send Resident #3 to the emergency room (ER) happened because the daughter requested the transfer. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/22/24 at 1:15 PM Staff B confirmed she didn't call Resident #3's family, but she reported Resident #3 complained of rib pain to Staff E. During an interview on 8/22/24 at 11:47 AM Staff C, Certified Medication Aide (CMA), indicated at the time of Resident #3's fall, she been in the dining room, when 1 of the CNAs reported Resident #3 fell . Staff C asked if she reported the incident to the nurse at which time she said yes. Staff C went to Resident #3's room and observed Staff B already present with Resident #3 lying flat on the floor between the table/dresser and closet with his head positioned underneath the desk area with a pillow under his head and his feet stretched out towards his recliner. Staff C noted his w/c parked by the window but didn't have any recollection of the position of his walker. Staff C indicated she felt the fall didn't seem too bad. Staff D assessed Resident #3, including range of motion (ROM), wrapped the skin tears on his elbow, and knuckles on his left arm/hand. Staff C confirmed Resident #3 complained that his ribs hurt and before his fall, he only complained of back pain but she found nothing unusual with her own visual assessment at the time. Following the assessment 4 staff members assisted Resident #3 off the floor with the use of a GB and positioned him in his w/c. During the transfer Resident #3 complained of pain again in his rib area. When Staff C asked Resident #3 if the pain felt like his normal back pain, he responded no, it felt new. Staff C then left Resident #3's room. Staff C indicated all of the incident occurred about 5-5:30 PM, but she returned to Resident #3's room around 6:30 PM. As he sat in his w/c, he acted per usual except his rib pain, she reported it as the only abnormal thing. As she administered his evening pills he requested to move to his recliner, as 2 CNA's walked by Resident #3's room so they took over. When asked how come they didn't send him to the emergency room (ER) right away r/t his new complaints of rib pain she stated the nurse made that call. During an interview on 8/22/24 at 3:47 PM Staff E confirmed she received a call close to 6 PM maybe even right at 6 PM, however, she had to deal with all the incidents from her shift making her busy. When Staff D arrived for his evening/night shift, she reported to him Resident #3 fell and sustained skin tears to his elbow. Staff E denied receiving report r/t Resident #3's complaint of rib pain. She asked Staff B if Resident #3 was OK, she responded yes. When asked about the facility's falls policy and procedure, Staff E replied the nurse assessed Resident #3 and called the Nursing Supervisor immediately. In the event the Nursing Supervisor had been busy with another resident or situation the nurses could call the Director of Nursing (DON). Staff E indicated a lot of times the Physician's failed to return call to the facility in a timely manner and the facility required a Physician's order to send a resident out to the ER. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/22/24 at 12:59 PM Staff D indicated during the evening in question he didn't receive report from Staff E until 6 6:30 PM due to her being in the middle of a report pertaining to Resident #3. Resident #3's daughter called and expressed concern about her father's left arm pain. Staff D understood Resident #3 fell around 5:15 PM, and the charge nurse assessed him. The report Staff E received reflected Resident #3 sustained a skin tear but no other injuries, so she reported she didn't assess him. Staff D indicated as a practice the Nursing Supervisors performed the fall follow-up assessments but had times they couldn't do it with 1 Nursing Supervisor for 165 residents so they had to triage. Staff D indicated when he got off the phone with the daughter he went to Resident #3's room and observed him as he sat in his w/c. Staff D performed ROM exercises but Resident #3 appeared to move everything just fine and without distress. Resident #3 presented a bandage the nurse used to cover the skin tear on his left arm, but she failed to secure the skin flap. Staff D rewrapped the area and also noted he had 0.2 centimeter (cm) by (x) 0.2 cm open areas on each knuckle of his left hand. Staff D then offered when he performed ROM exercises to Resident #3 he complained of upper left-sided rib pain which he rated a 5 out of 10. Resident #3 grimaced a bit after lifting his left arm but didn't have SOB or anything like, but Staff D failed to assess Resident #3's lung sounds. After the assessment Staff D called Resident #3's daughter and told her he had rib pain. When Staff D asked if she wanted Resident #3 sent to the ER, she responded due to his previous back fractures she wanted him sent out. Staff D called the on call Physician and received orders to send him to the ER but had to call 2 times that night which sometimes happened. Staff D confirmed he would call the family first to ask them what they wanted done and then he'd called the Physician. Staff D thought Resident #3 called his family himself and notified them of his fall. Staff D indicated Staff B gave him no indication of an emergent situation and when he first assessed Resident #3 he showed no signs of emergent pain. However, when he transferred to the EMS gurney he guarded his left side and his O2 sats went down so the EMS crew requested him to deep breath and applied oxygen. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview per facility request on 8/27/24 at 9:58 AM Staff D indicated generally, he arrived to work at 6 PM and received report. That day, he took over for Staff E who ran behind so he received report closer to 6:30 PM. Staff E reported Resident #3 fell and sustained a skin tear to his left elbow however she did not get a chance to have performed a follow-up assessment. About half-way through their report, around 6:40 PM, Resident #3's daughter called and reported her dad fell and complained of left arm pain. Staff D told the daughter he planned to go down to Resident #3's room after they finished report. Staff D received a call from the Pharmacist who reported they entered the building with medications close to 7 PM. Staff D went to Resident #3's room as Staff E assisted the Pharmacist. When Staff D entered Resident #3 room, he sat in his w/c almost straight up but off to the side close to his recliner. When question how he felt by Staff D, Resident #3 replied OK but his arm hurt. Staff D performed ROM but when he got to his left arm he reached around and grabbed just under his axilla area adjacent to his breast. Staff D palpated the area and felt no crackling, protrusions, bruising or swelling. Resident #3 reported as he sat in his lift chair he used his walker to stand and attempted to transfer to his w/c with his wife's assistance rather than the staff. When asked how they performed the transfer, Resident #3 replied he had his walker positioned in front of him in his easy chair while his wife stood to his back and side. His wife pushed on his back as he turned with his walker and in the process his wife turned the w/c so as he sat down his left side ran down the right arm rest of the w/c and his axilla slammed into the arm rest. Staff D noticed the nurse wrapped his left elbow with gauze but she didn't reattach the skin flap so he rewrapped the area. Staff D again asked Resident #3 how he felt as Resident #3 complained his ribs hurt on the left upper side. The entire assessment took about a half hour. Staff D left and called Resident #3's daughter who verbalized concerns because he fell a lot at home. She said he didn't use his call light because no one answered it and it took up to 1 hour for response. Staff D indicated their phone call lasted about 20 minutes as he offered apologizes. When asked if she wanted him sent out for evaluation, she replied yes. After Staff D prepared the required paperwork, he went downstairs as the EMS crew arrived. They all went to Resident #3's room as Staff D noted the staff transferred him to his lift chair while he worked upstairs. After Resident #3 answered the EMS' questions, the paramedics put down his foot rest and raised his lift chair to the point his seat sat at a 30-degree angle. At that time Resident #3 used his left arm and guarded the left side. When he did that he started to hold his breath and took little wincing breaths due to (d/t) pain. At that time, he guarded his left side as he held his breath so his O2 saturation (sat) dropped to 87%. The paramedic encouraged him to take deep breaths which caused him discomfort, but rose his O2 sat to 95%. The paramedics brought the gurney in front of Resident #3's lift chair across the knees at which time Staff D offered to get the lift device and they said no we can get him. At that point, each of the crew members grabbed under Resident #3's arms and lifted him up as he yelled out in pain it hurts, it hurts. The crew said we know it hurts but we have to do it to get you to the hospital. They got him up and pivot transferred him to the gurney. They lifted his legs and applied O2. Staff D indicated the whole time he observed Resident #3 until the paramedics lifted him up he didn't observe any respiratory issues. Staff D indicated when the crew lifted him up, he noted a small little bruise that presented as a shading type area and/or the start of a bruise. The crew then left the facility with Resident #3. Staff D again reiterated he didn't witness Resident #3 with any immediacy until the ambulance crew transferred Resident #3 to the gurney. During an interview on 8/22/24 at 2:23 PM one of Resident #3's daughter voiced frustration that her father sat there so long in pain. Review of Resident #3's daughter's call logs revealed the following telephone calls to and from the facility and/or her mom and dad on 8/13/24 as specified and dated: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Mom called daughter at 6:24 PM and reported the fall. Daughter spoke with her father who reported his side hurt. b. Daughter called the facility at 6:42 PM for 1 minute and again at 6:44 PM for 3 minutes. c. Daughter called Staff F, Social Worker, at 6:29 PM for 6 minutes. d. The facility called Resident #3's daughter at 7:01 PM for 4 minutes. e. Daughter called Staff D at 7:07 PM for 8 seconds, again at 7:07 PM for 9 seconds, and again at 7:08 PM for 4 seconds. According to an EMS/Fire Department report dated 8/13/24 the facility called EMS at 7:56 PM, they dispatched (sending someone to a destination or purpose) at 7:57 PM, enroute to the facility at 7:58 PM, on scene at 8:02 PM, and with Resident #3 at 8:03 PM. They departed from the facility at 8:19 PM and arrival at the hospital at 8:25 PM. The ambulance crew's assessment/documentation included the following: a. Injury to the Thorax (upper chest) from a slip, trip or stumble. b. Acute pain d/t blunt trauma to the left ribs. c. Blood on the left side. d. Moderate distress. e. At 8:04 PM Resident #3 presented with left sided anterior and posterior pain during inspiration and expiration, left upper and lower lobes to his lungs with decreased breath sounds, a contusion (bruise) to his left upper abdomen f. Vitals at: - 8:07 PM included a pulse (P) of 64, respirations 16, and an oxygen sat of 87% at room air with pain identified at a 10 level. - 8:17 PM Resident #3's blood pressure (b/p) of 144/89, pulse 60 and an oxygen saturation rate 96%. - 8:24 PM Resident #3's B/P registered at 136/81, P at 68 and an oxygen saturation rate of 92%. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165072	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Health Center	302 Second Street NE Mason City, IA 50401

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	g. The narrative documentation included the following: Resident #3 alert and oriented x 3 (person, place and time) but unsure of the day or month. Resident #3's nurse stated he fell from a standing positioning forward onto the arm of his wheel chair. Resident #3 complained of extreme pain to his left ribs and had some minor bleeding from his left arm. Resident #3's wife stated she tried to help him into the wheelchair when he fell . Resident #3 stated his experienced pain just he sat and breathed. The initial oxygen sat registered at 85% at room air. Resident #3's wife stated his face looked puffy but both Resident #3 and the nurse said his face looked normal. Post assessment the crew placed Resident #3 on 2 liters of oxygen per nasal cannula, assisted him out of his chair, onto the cot, and transferred him to the local hospital. During an interview on 8/23/24 at 2:00 PM 2 EMS supervisors, EMS 1 and EMS 2, arrived at the facility on their own accord and requested a conversation with the Surveyor. When asked why they failed to use lights and sirens when they transported Resident #3 to the ER, EMS 1 suggested due to extensive studies lights and going fast are more detrimental to the patient and the use of sirens cause more accidents. During the meeting they called EMS 3, Paramedic, who responded to the transfer she indicated upon arrival Resident #3 sat in his recliner chair. EMS 3 confirmed she and her crew member, EMS 4, Paramedic, stood Resident #3 and pivot transferred him to his gurney however he showed no signs of substantial pain with the transfer process. EMS 3 described Resident #3's O2 sats registered in the 80's on their initial arrival but with coaching and O2 sats bounced back to within normal limits (WNL), or greater than 90% oxygen level. EMS 3 indicated Resident #3's wife kept saying his face looked puffy. When she asked Staff D he downplayed it and said the puffiness presented as Resident #3's norm. So, without knowing Resident #3, they maintained his stability for the short transfer to the ER. During another interview on 8/28/24 at 10:46 AM EMS 1 confirmed the medics transferred Resident #3 by placing their arms under Resident #3's arms. Their standard of practice directed this when a resident/patient assisted with the transfer process but that wouldn't cause the punctured lung. The Hospital's History and Physical form dated 8/14/24 at 2:16 AM documented by the Physician, they felt Resident #3 had inconsistent injuries with the stated cause of his injuries. The facility notified Resident #3's daughter her father fell . She then requested the facility to transfer her father to the ER for evaluation. The staff described Resident #3 as fine and felt an evaluation in the ER unnecessary. Then Resident #3's second daughter became involved, she too expressed concern, and asked the staff to transfer her father to the ER. A hospital's Discharge Summary *Final Report* form printed on 8/18/24 at 4:41 PM included the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #3 admitted to the hospital for a left pneumomediastinum (air present in the mediastinum, area between the lungs) s/p (following a procedure) a chest tube (chest tube used to treat a collapsed lung), pneumopericardium (rare condition that occurred when air or gas accumulated in the pericardial sac (tissue sac that surrounded the heart often caused by a blunt or penetrated chest trauma) and multiple fractures. He sustained a left skin tear of his forearm and had a 11/10 left sided rib pain. Patient arrived to the emergency room awake and alert as he talked appropriately and moved all extremities. He presented in respiratory distress and intubated (a tube placed in the trachea for maintenance of an open-air way and a means for facilitation of ventilation to the lungs which included a mechanical ventilation device). A noncontrast head and C spine test revealed an apical pneumothorax (collapsed lung near the apical zone of the lung otherwise known as an area above the 1st rib). Other imaging revealed bilateral subcutaneous emphysema (trapped air) throughout the neck, moderate sized left pneumothorax, mildly displaced fracture of the left lateral clavicle, nondisplaced fracture of the left acromion (broken bone in the shoulder blade), displaced fractures of the left posterior 2nd through 8th ribs, minimally displaced fractures of the left 1st thru the 5th ribs anteriorly, nondisplaced fractures of the right posterior lateral 1st and 2nd ribs, left lower lobe consolidation and acute fractures of the L1 and L2 vertebral bodies. The family decided to terminally extubate Resident #3 and transition him to comfort measures. The form indicated Resident #3 passed away on 8/17/24. During an interview on 8/22/24 at 11:10 AM a hospital Case Manager explained she had concern with the delayed response for the care and treatment of Resident #3. She understood the facility had contact with their provider and the family wanted him out. The facility told the family they had to get prior permission before they could send him to the ER. During an interview on 8/23/24 at 12:55 PM Resident #3's primary Physician confirmed he expected the staff to send Resident #3 to the ER per family request and his acute situation with left rib pain, considering his comorbidities (multiple diagnoses) even if they couldn't initially correspond with him and/or the Physician on-call.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25854 Based on observation, resident, and family interview, the facility failed to answer resident call lights in a timely manner and within the regulated 15-minute time frame for 3 of 5 residents reviewed (Resident #3, #4 and #5). The facility reported a census of 165 residents. Findings include: 1. On 8/23/24 at 11:53 AM observed Resident #4's call light on. According to the call light monitor at the nurse's station on the 1 [NAME] hallway the call light had been on for 16 minutes and counting. On 8/23/24 at 11:54 AM Staff G, Licensed Practical Nurse (LPN), entered the room. Staff G brought in a nutritional drink and Resident #4's pain patch. Staff G became defensive when she spoke with Resident #4 and his daughter. She spoke in a derogatory tone, rolled her eyes, and made negative facial expressions. Resident #4's family member (RR #4) asked if the surveyor saw that and reported Staff G always addressed her mother and/or herself that way. During observation, Staff G failed to address Resident #4's call light to see if someone helped her or if she still needed help. On 8/23/24 at 12:05 PM 2 unknown Certified Nurse Aides (CNAs) entered the room and shut off her call light. During that timeframe, observed Resident #4 feeling unwell with a flat facial expression. On 8/23/24 at 12:10 PM Resident #4's daughter reported the facility planned to send Resident #4 to the hospital due to having a temperature and potential dehydration after the nurse assessed her. 2. During an interview on 8/22/24 at 2:23 PM Resident #3's daughter reported the facility failed to answer Resident #3 call lights in a timely manner. Which at times took up to one (1) hour which caused frustration for him so he self-transferred. This daughter offered that she visited her parents 1 2 times a week for at least 4 hours and no staff member came in to check on them. The daughter confirmed she witnessed her father put on his call light while she visited. Although she never timed how long it took the staff to answer his call light, she knew it caused him frustration as he sat in clothing soiled with urine. The Communication with Family/NOK/POA on 8/13/24 at 7:29 PM reflected as the facility discussed Resident #3's fall with his daughter, she voiced frustration that he came to the facility due to falls at home and he had 2 falls since his admission. Resident #3's daughter reported in the past Resident #3 had to wait well over an hour for assistance when he turned on his call light and that's why he transferred himself. The note indicated the writer explained if that is correct that that is a concern to them and they would speak to the staff about the importance of answering call lights in the timeliest fashion, however Resident #3 stated he did not call for assistance because he and his wife live together and she can take care of his needs. Resident #3's daughter stated she talked to him about it in the past and she would like to follow-up with the care plan and a social worker to come up with a plan to prevent this. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an interview on 8/27/24 at 4:03 PM Resident #5 explained she timed having call light on for up to 45 minutes, as she used the clock on the wall. This caused pain when they left her on the commode. Resident #5 declared the call light issue occurred on every shift. 4. On 8/27/24 at 12:14 PM observed room [ROOM NUMBER]'s call light on. According to the call light monitor at the nurse's station on 1 [NAME] hallway the call light had been on for 17 minutes and counting. The Resident Rights document provided by the facility dated October 2017 instructed the resident had the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely.