Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165072	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024

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 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** 41537 Based on record review, staff interviews, and policy review the facility failed to ensure 1 of 3 residents (Resident #1) did not fall when getting off of the facility van. The facility reported a census of 153 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview of Mental Status (BIMS) score of 13, indicating he intact cognition. The MDS listed Resident #1 as independent with transfers, walking, personal hygiene, and using the toilet. The MDS included diagnoses of cancer, hypertension (high blood pressure), and malnutrition (inadequate nutritional intake). Resident #1 received hospice services within the lookback period. The Fall with Injury Incident Report dated 9/2/24 at 12:32 PM reflected the receptionist called the staff to report a resident who fell in the driveway. Resident #1 complained of tenderness of his right wrist a few minutes after returning to his room. He could move it freely and had no deformity. Despite encouragement to go to the ER for evaluation, Resident #1 and his family declined to go. The untitled and undated investigation completed by the facility for Resident #1's fall on 9/2/24 indicated Resident #1 fell in his room during a self-transfer. Following the fall, he went to the emergency room (ER) and received sutures (stitches) above his left eyebrow. After returning to the facility, the facility van driver accidentally left the van lift in the ground level position. As the van driver walked backwards off the van, he fell backward to the lift, pulling Resident #1 out of the van to the ground with him. As the driver attempted to get up, he slowly tipped Resident #1 to the left side, causing him to slide out of the wheelchair into a lying position. Resident #1 reported he felt fine and did not hit his head. Later in the day, Resident #1 complained of wrist pain, when facility offerred to take him to the hospital, he declined to go for an evaluation and his family who witnessed the incident declined as well. The Plan indicated the facility terminated the van driver on 9/2/24. The facility updated their policy to add a requirement for any transports to have the driver and one additional person standing by for the loading and unloading of the van to ensure safety on 9/2/24. The facility reeducated the staff who operate the facility van on the new process on 9/3/24. The facility planned to give the policy to all new hires who drive the van on 9/3/24. Record review of a document titled Quality Assurence (QA) Meeting, dated 9/3/24 documented education to all van drivers employed by the facility. (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

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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

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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	During an interview on 9/6/24 at 2:15 PM the Administrator reported Resident #1 fell by accident and they reeducated all employees on how to use the van. The facility policy, Post Fall Protocol dated 8/24/24 revealed the facility followed their policy and procedures related to Resident #1 fall on 9/2/24.