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	03/13/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858 Based on clinical record review, policy/procedure review, and staff interview the facility failed to treat a resident with respect and dignity in a manner that promotes maintenance or enhancement of his or her quality of life for 1 out of 3 resident reviewed. (Resident #2). The facility identified a census of 151 residents. Findings include: Resident #2's Minimum Data Set assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition., documented diagnoses for which included Benign Prostatic Hyperplasia (BPH), diabetes mellitus, arthritis, recent hip fracture and mild cognitive impairment. The MDS revealed Resident #2 with a Brief Interview for Mental Status (BIMS) score of 5 for which indicated severe memory impairments, is able to be understood and understand by others, and displayed verbal behavioral symptoms directed toward others, (threatening others, screaming at others, cursing at others) other behavioral symptoms not directed toward others (physical symptoms such as hitting or scratching self, pacing, or verbal/vocal symptoms like screaming, disruptive sounds) and substantial to maximal assistance with all activities of daily living (ADL) including ambulation and transfer, and frequently incontinent of bladder and bowel. The Care Plan Focus initiated 12/10/24 reflected Resident #2 required assistance with activities of daily living (ADLs) due to a right hip fracture, pubic rami fracture (2/13/25) with surgical repair. The Care Plan Interventions directed the following: a. Initiated 2/4/25: Resident #2 required assistance from 2 staff and a standing mechanical lift. Resident #2 didn't like the use of the gait belt and will slap staff hands away when trying to apply the gait belt. Educate the reason for the gait belt and he would usually allow. Resident #2 didn't walk and used a wheelchair for all mobility. allow. Resident #2 didn't walk and used a wheelchair for all mobility. b. Revised: 2/12/25: Resident #2 required assistance of 2 staff with toilet use. He wore protective undergarments and needed assistance with perineal cares. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan Focus initiated 12/10/24 indicated Resident #2 had a risk for elopement and wandering due to a diagnosis of dementia/Alzheimer's disease. He has a history of attempting to leave the facility unattended and wanders aimlessly. The Interventions instructed to anticipate his wants and need as he may not always verbalize them. Resident #2's Incident Report dated 3/8/25 at 12:00 AM, identified Alleged Abuse: Staff A, Certified Nurse Aide (CNA), approached the nurse and told them about an incident that happened the previous night on 3/7/25, involving Staff B, CNA, and Resident #2. Staff A explained Staff B, Staff C, CNA, and themselves entered Resident #2's room because he pressed his call light and stated he needed to go to the bathroom. As the CNAs got him in the standing mechanical lift when Resident #2 started to become agitated asking what they were doing, they explained they were assisting him to the restroom as he requested. Resident #2 accepted the explanation. As they assisted him to use the toilet, he became agitated, the nurse entered the room at that time and told Resident #2 to please not yell at the aides that tried to help him. He told the nurse he just wanted to know why his leg hurt, the nurse explained to Resident #2 he came to the facility because he broke his hip. He calmed down and replied okay he just wanted to know what was going on. The nurse exited the room at that time to attend to another resident. Staff A stated Resident #2 began to yell at them again a few moments later and hit Staff B. Staff B then smacked Resident #2s left hand 3 times and said you do not hit me. Resident #2 became more agitated and yelled at Staff B calling her a stupid bitch. Staff B responded back to Resident #2 saying NO, you are a stupid bitch. Resident #2 then said shut up and Staff B said No you shut the fuck up? Staff A and Staff C didn't alert the nurse of the incident immediately. Staff C went home sick soon after the incident. Resident #2 couldn't give a description. The nurse notified the supervisor and immediately called the Director of Nursing (DON) and Staff B's employment agency. The nurse notified Staff B their contract ended effective immediately. The nurse filled out the Incident Report and did an assessment of Resident #2. The undated Facility Summary documented Resident #2 resided at the facility since 12/10/24. He had diagnoses of a fracture of his right femur neck (prior to admission), diabetes, dementia with mood disturbance, and osteoarthritis. He had a BIMS of 3. He required the use of equipment and 2 staff for transfers. Resident #2 received Tylenol for pain. He had no safety awareness, and repeatedly attempted to transfer himself without asking for assistance or using his call light. He became agitated at attempts to help him with cares and would hit, curse, and bite staff. Resident #2 had a long history of falls at home. On the evening of 3/8/25 Staff A, reported to her nurse that on the previous evening, 3/7/24, they witnessed Staff B strike Resident #2 on the back of his hand 2 3 times. The nurse elevated the Incident to the House Supervisor. The staff made notifications to the DON and Administrator. Staff B was present at the time and was immediately sent home. The investigation included staff statements and the DON contacted Staff B for a statement via telephone. The facility reported to the DON and Administration Resident #2 didn't have a bruise on their hand. There is documentation describing Resident #2's combative behavior in the time leading up to this incident. There are episodes in the nursing documentation for 3/1/25 and 3/4/25, where Resident #2 hit staff. One can expect that during a hitting motion, Resident #2 could receive bruising on inside of arms/wrists. The facility completed weekly skin checks. a. Dismissed accused individual. b. Educated the reporting individual on the importance of timely reporting. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Facility provided education at hire and at annual in services on dependent adult abuse, reporting and response d. Contract staff had dependent adult abuse education of file. The Behavior Note dated 3/1/25 at 1:54 PM indicated Resident #2 yelled at staff when instructed to wait a moment, due to waiting on another staff member to assist as he required 2 staff for assistance. Resident #2 pushed, spit, and hit staff during incontinent care and transfers. The staff unable to successfully redirect him. The Communication - with Physician Note dated 3/4/25 at 1:32 PM reflected the staff reported Resident #2 continued to be combative with cares. The staff reported he hit, kicked, scratched, and bit them. The Incident Note dated 3/8/25 at 11:30 PM indicated Staff A, Certified Nurse Aide (CNA), approached the nurse and told them about an incident that happened the previous night on 3/7/25, involving Staff B, CNA, and Resident #2. Staff A explained Staff B, Staff C, CNA, and themselves entered Resident #2's room because he pressed his call light and stated he needed to go to the bathroom. As the CNAs got him in the standing mechanical lift when Resident #2 started to become agitated asking what they were doing, they explained they were assisting him to the restroom as he requested. Resident #2 accepted the explanation. As they assisted him to use the toilet, he became agitated, the nurse entered the room at that time and told Resident #2 to please not yell at the aides that tried to help him. He told the nurse he just wanted to know why his leg hurt, the nurse explained to Resident #2 he came to the facility because he broke his hip. He calmed down and replied okay he just wanted to know what was going on. The nurse exited the room at that time to attend to another resident. Staff A stated Resident #2 began to yell at them again a few moments later and hit Staff B. Staff B then smacked Resident #2s left hand 3 times and said you do not hit me. Resident #2 became more agitated and yelled at Staff B calling her a stupid bitch. Staff B responded back to Resident #2 saying NO, you are a stupid bitch. Resident #2 then said shut up and Staff B said No you shut the fuck up? Staff A and Staff C didn't alert the nurse of the incident immediately. Staff C went home sick soon after the incident. After reporting the incident to the Nursing Supervisor, they directed the nurse to assess Resident #2. The assessment of Resident #2's hands and wrists identified a reddened area to his left wrist that measured 2 centimeters (CM) by 1.2 CM, in the area Staff A reported Staff B hit. Additionally, the nurse noted 2 bruises on his top right hand and wrist measuring 3 CM by 2.1 CM on the hand with a 3 CM by 3 CM on the wrist. Interview on 3/11/25 at 4:30 PM, The facility Director of Nursing (DON), verified they expected all staff to treat residents with dignity and respect per the policy/procedure. Interview on 3/12/25 at 10:00 AM, the Facility Administrator confirmed all residents are to be treated with respect and dignity from staff at all times. The Resident Rights dated October 2017, documented the resident had the right to a dignified existence, self determination, and communication with and access to persons and services inside and outside the facility. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promoted maintenance or enhancement of his or her quality of life, recognizing each resident individuality. The facility must protect and promote the rights of the resident.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858 Based on clinical record review, Resident [NAME] of Rights, facility investigation, staff interview, and review of policy and procedures, the facility failed to report an allegation of abuse to the Department of Inspection and Appeals and Licensing (DIAL) for 1 of 3 residents reviewed (Resident #2) within the required 2-hour timeframe. Staff A, Certified Nurse Aide (CNA), alleged the witnessed Staff B, CNA, hit Resident #2 on 3/7/25. Staff A failed to report the incident to the facility until 3/8/25, after the 2-hour window when they witnessed the alleged incident. The facility reported a census of 151 residents. Findings include: Resident #2's Minimum Data Set assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition., documented diagnoses for which included Benign Prostatic Hyperplasia (BPH), diabetes mellitus, arthritis, recent hip fracture and mild cognitive impairment. The MDS revealed Resident #2 with a Brief Interview for Mental Status (BIMS) score of 5 for which indicated severe memory impairments, is able to be understood and understand by others, and displayed verbal behavioral symptoms directed toward others, (threatening others, screaming at others, cursing at others) other behavioral symptoms not directed toward others (physical symptoms such as hitting or scratching self, pacing, or verbal/vocal symptoms like screaming, disruptive sounds) and substantial to maximal assistance with all activities of daily living (ADL) including ambulation and transfer, and frequently incontinent of bladder and bowel. Resident #2's Incident Report dated 3/8/25 at 12:00 AM, identified Alleged Abuse: Staff A, Certified Nurse Aide (CNA), approached the nurse and told them about an incident that happened the previous night on 3/7/25, involving Staff B, CNA, and Resident #2. Staff A stated Resident #2 began to yell at them again a few moments later and hit Staff B. Staff B then smacked Resident #2's left hand 3 times and said you do not hit me. Resident #2 became more agitated and yelled at Staff B calling her a stupid bitch. Staff B responded back to Resident #2 saying NO, you are a stupid bitch. Resident #2 then said shut up and Staff B said No you shut the fuck up? Staff A and Staff C didn't alert the nurse of the incident immediately. Staff C went home sick soon after the incident. Resident #2 couldn't give a description. The nurse notified the supervisor and immediately called the Director of Nursing (DON) and Staff B's employment agency. The nurse notified Staff B their contract ended effective immediately. The nurse filled out the Incident Report and did an assessment of Resident #2. The undated Facility Summary identified on the evening of 3/8/25 Staff A, reported to the nurse that on the previous evening, 3/7/24, they witnessed an incident of Staff B struck Resident #2 on the back of the hand 2 3 times. The facility reported the incident to the House Supervisor, the DON and the Administrator. Staff B worked at the time of notification and was immediately sent home. The facility completed the following: a. Dismissed accused individual. b. Educated the reporting individual on the importance of timely reporting. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Facility provided education at hire and at annual in services on dependent adult abuse, reporting and response d. Contract staff had dependent adult abuse education of file. The Incident Note dated 3/8/25 at 11:30 PM indicated Staff A, Certified Nurse Aide (CNA), approached the nurse and told them about an incident that happened the previous night on 3/7/25, involving Staff B, CNA, and Resident #2. Staff A explained Staff B, Staff C, CNA, and themselves entered Resident #2's room because he pressed his call light and stated he needed to go to the bathroom. As the CNAs got him in the standing mechanical lift when Resident #2 started to become agitated asking what they were doing, they explained they were assisting him to the restroom as he requested. Resident #2 accepted the explanation. As they assisted him to use the toilet, he became agitated, the nurse entered the room at that time and told Resident #2 to please not yell at the aides that tried to help him. He told the nurse he just wanted to know why his leg hurt, the nurse explained to Resident #2 he came to the facility because he broke his hip. He calmed down and replied okay he just wanted to know what was going on. The nurse exited the room at that time to attend to another resident. Staff A stated Resident #2 began to yell at them again a few moments later and hit Staff B. Staff B then smacked Resident #2's left hand 3 times and said you do not hit me. Resident #2 became more agitated and yelled at Staff B calling her a stupid bitch. Staff B responded back to Resident #2 saying NO, you are a stupid bitch. Resident #2 then said shut up and Staff B said No you shut the fuck up? Staff A and Staff C didn't alert the nurse of the incident immediately. Staff C went home sick soon after the incident. After reporting the incident to the Nursing Supervisor, they directed the nurse to assess Resident #2. The assessment of Resident #2's hands and wrists identified a reddened area to his left wrist that measured 2 centimeters (CM) by 1.2 CM, in the area Staff A reported Staff B hit. Additionally, the nurse noted 2 bruises on his top right hand and wrist measuring 3 CM by 2.1 CM on the hand with a 3 CM by 3 CM on the wrist. Interview on 3/10/25 at 9:30 AM, the facility Administrator confirmed the facility failed to notify DIAL of the incident between Resident #2 and Staff B within the 2-hour time frame. The Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated December 2022, instructed all allegations of resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegation of abuse to the Administrator, or designated representative. All allegations of resident abuse shall be reported to the Iowa Department of Inspections and Appeals no later than 2 hours after the allegation is made.

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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 0713 Level of Harm - Actual harm Residents Affected - Few	Provide or arrange emergency care by a doctor 24 hours a day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858 Based on observation, clinical record review, staff interview, and facility policy/procedure review at the time of the investigation, the facility failed to intervene timely for a resident who needed had a change in condition following a fall on 2/3/25 for 1 of 4 residents reviewed (Resident #2). At Resident #2's admission in December 2024, he came to the facility with a repaired fractured right hip due to a fall at home. Due to his cognition, he frequently forgot he previously had a hip fracture and would frequently transfer by himself. On 2/3/25, he had an unwitnessed fall. When the nurse assessed him, he reported pain to his right hip. After the nurse's assessment, 2 Certified Nurse Aides (CNAs) assisted Resident #2 from the floor and back into bed. Despite Resident #2's recent surgical repair of his right hip, the nurse faxed the physician instead of sending him for evaluation. Resident #2 continued to report pain during the nurses' assessments to his right hip and needed assistance of 2 staff for transfers. On 2/5/25, the nurse contacted the Orthopedic provider about Resident 2's pain to his right hip. Despite Resident #2's decline in condition, the facility failed to intervene with emergency services until a nurse sent him to the emergency room (ER) for evaluation on 2/8/25. The ER evaluation reflected Resident #2 received treatment for a right pubic rami fracture (fracture of pelvis), hypoxia (low blood oxygen levels), and COVID-19. The facility identified a census of 151 residents. Findings include: Resident #2's Minimum Data Set assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. Resident #2 displayed verbal behavioral symptoms directed toward others (threatening others, screaming at others, cursing at others) and other behavioral symptoms not directed toward others (physical symptoms such as hitting or scratching self, pacing, or verbal/vocal symptoms like screaming, disruptive sounds). Resident #2 required substantial to maximal assistance with all activities of daily living (ADL) including ambulation and transfer. The MDS listed him as frequently incontinent of bladder and bowel. The MDS included diagnoses of benign prostatic hyperplasia (BPH), diabetes mellitus, arthritis, recent hip fracture, and mild cognitive impairment. The Care Plan Focuses: a. Revised 2/17/25 identified Resident #2 required assistance with activities of daily living related to his right hip fracture with surgical repair and a right pubic rami fracture. The Interventions reflected the following: i. Revised 12/30/24: Physical Therapy (PT) and Occupational Therapy (OT) evaluate and treat as ordered by the physician. ii. Resolved 2/12/25: Transfers/walking: Per therapy alert 12/27/24: Transfer assist of 1 with gait belt and front wheeled walker. Ambulation with gait belt, front wheeled walker, and assist of 1. Encourage Resident #2 to walk outside of the room at least twice per day. (continued on next page)

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F 0713 Level of Harm - Actual harm Residents Affected - Few	iii. Revised 2/17/25: Resident #2 lived at the facility due to his impulsivity and attempts to self-transfer without waiting for assistance. He doesn't remember to use his call light or that he fractured his hip in the past. iv. Revised 2/17/25: Resident #2 required assistance from 2 staff and a standing mechanical lift. Resident #2 didn't like the use of the gait belt and would slap the staff hands away when they tried to apply a gait belt. When staff educated the reason for the gait belt, he usually allowed them to use it. Resident #2 didn't walk and used a wheelchair for all mobility. Resident #2 didn't walk and used a wheelchair for all mobility. b. Revised 12/10/24: Resident #2 had unspecified arthritis. The Interventions directed the following: i. Daily range of motion (ROM) exercises both active (moved by self) and passive (moved by someone else) as tolerated. ii. Monitor/document/report to medical doctor as needed signs/symptoms or complications related to arthritis: joint pain, joint stiffness, usually worse on waking, swelling, decline in mobility, decline in self-care ability, contracture (stiffness in a body part that restricts movement usually in a bent position) formation/joint shape changes, crepitus (creaking or clicking with joint movement), pain after exercise or weight bearing. Resident #2's February 2025 Medication Administration Record included an order dated 12/9/24 for acetaminophen (Tylenol) 500 milligrams (MG), take 2 tablets (1000 MG) by mouth twice daily as needed (PRN) for pain or fever greater than 100.4 degrees Fahrenheit (F). Do not exceed 4000 MG in 24 hours. Documentation reflected Resident #2 received the following dose of acetaminophen on: a. 2/3/25 at 6:54 PM, for pain level 6 (on a 0 to 10 pain scale), indicating moderate pain. b. 2/4/25 at 7:36 AM, for pain level 5, indicating moderate pain. c. 2/4/25 at 6:26 PM, for pain level 8, indicating severe pain. d. 2/5/25 at 8:29 AM, for pain level 4, indicating moderate pain. e. 2/6/25 at 7:43 PM, for pain level 6, indicating moderate pain. f. 2/7/25 at 12:08 PM, for pain level 8. g. 2/8/25 at 9:30 AM, for pain level 8. h. 2/8/25 at 1:41 PM, for pain level 9, indicating severe pain. The Behavior Note dated 2/3/25 at 4:37 AM, Resident #2 got up five times and moved on their own. They proved hard to guide and sometimes acted aggressive. (continued on next page)

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F 0713 Level of Harm - Actual harm Residents Affected - Few	The Incident Note dated 2/3/25 at 7:47 PM, the CNA told the nurse they saw Resident #2 on the floor in the bathroom. The CNA contacted the house supervisor because of the nurse being busy at the time. The house supervisor completed an initial assessment and helped transfer Resident #2 from the floor to the bed. The nurse later conducted a follow-up fall assessment. Resident #2 laid awake in bed when the nurse entered. When asked what happened, Resident #2 said, I'm being stupid. I tried to get up when I shouldn't have. Resident #2 denied hitting their head, but reported pain in their right hip when the nurse checked their range of motion (ROM). He couldn't rate the pain due to his altered mental status. The nurse administered acetaminophen for pain, but Resident #2 refused other pain treatments. Resident #2 remained at baseline, oriented to person but not time or place. The nurse couldn't check Resident #2's pupils because he refused. Resident #2's speech remained clear. He had decreased lung sounds in both lower lungs but stayed clear otherwise. He had equal grip strength felt on both sides. No sign of complications in the right hip repair appeared during the assessment. Resident #2 refused a skin check, saying, I'm fine. Just leave me alone. The fall went unwitnessed. The nurse completed a neurological assessment, still in progress, with no concerns noted at the time. The Incident Note dated 2/3/25 at 7:50 PM, the nurse received a call to Resident #2's room, where the CNA found him on the bathroom floor. Resident #2 laid on his back with his feet in front of the toilet, wearing socks. Resident #2 stated he needed to urinate but was in bed. The call light sat within reach but remained off, and the urinal rested by the bedside. Resident #2 wore loose pajama pants that slid down when he walked, requiring him to hold them up with one hand. The draw straps on the pants got tightened to prevent them from falling down easily. No internal or external hip rotation or leg shortening appeared. Resident #2 complained of discomfort in his right posterior thigh, where some muscle stiffness showed. 2 staff members assisted him to his feet and helped him walk to his bed with a gait belt and walker. The assessment identified no red areas, bruising, or crepitus (popping noise heard when moving joints). The nurse reminded Resident #2 to use the call light and urinal. The N Adv - Neurologic Focused Evaluation dated 2/4/25 at 12:24 AM, Pain Issue: New location in Resident #2's right hip. Pain score reached 7. Described as aching and non-radiating. Pain occurred intermittently. Resident #2 refused non-medication interventions, and these didn't provide relief. The nurse provided an as-needed (PRN) medication. Pain indicators included protective body movements, facial expressions, and vocal complaints. Resident #2 showed signs of disorientation, confusion, and disorganized thinking. Short-term memory loss appeared. Resident #2 remained oriented to person, made themselves understood, and understood others. Resident #2 also showed signs of agitation. The N Adv - Post Fall Evaluation dated 2/4/25 at 12:32 AM identified Resident #2 fell unwitnessed, in the bathroom. Resident #2 tried to use the bathroom alone at the time of the fall. The staff determined the cause of the fall as Resident #2 attempted to use the bathroom by himself without a cane or walker as instructed. The assessment reflected no injury from the fall. Resident #2 had the following indicators of pain: verbal, non-verbal sounds, and facial expressions. He rated his pain score a 3 on a 10-point scale (0 equals no pain and 10 equals the worst pain). The Evaluation indicated this as a change for Resident #2. (continued on next page)

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F 0713 Level of Harm - Actual harm Residents Affected - Few	A Nursing Facsimile (fax) form dated 2/4/25 at 12:36 AM, documented on 2/3/25 identified at 7:40 PM, the CNA found Resident #2 on the bathroom floor. Resident #2 laid on his back with his feet in front of the toilet, wearing socks. Resident #2 said he needed to urinate but was in bed. The call light sat within reach but stayed off, and the urinal rested by his bedside. Resident #2 wore loose pajama pants that slid down when he walked, so he had to hold them up with one hand. The draw straps on the pants got tightened to keep them from falling down. The assessment revealed no internal or external hip rotation or leg shortening. Resident #2 complained of discomfort in his right posterior thigh, where it had some muscle stiffness. 2 staff members helped Resident #2 to his feet, used a gait belt, and a walker to assist him back to bed. The Health Status Note dated 2/4/25 at 9:14 AM indicated a follow-up assessment of Resident #2 after his unwitnessed fall. He had an occasional nonproductive cough with a soft, non-tender abdomen. Resident #2 complained of right hip pain and needed 2 people to help with transfers. Resident #2 received PRN Tylenol for pain. The Health Status Note dated 2/4/25 at 11:58 PM reflected Resident #2 had an unwitnessed fall. Resident #2 complained of pain to his right hip and needed 2 people to help him transfer. Resident #2 received PRN Tylenol for pain. The Health Status Note dated 2/5/25 at 9:59 AM reflected a follow-up assessment of Resident #2's unwitnessed fall. He could complete an active and passive range of motion within normal limits. Resident #2 needed 2 people to help him transfer due to right hip pain. The Health Status Note dated 2/5/25 at 12:11 PM, reflected the nurse called Ortho (bone doctor) and left a message to ask if Resident #2 needed an x-ray or appointment for his right hip pain. The Health Status Note dated 2/6/25 at 1:43 AM, identified the nurse monitored Resident #2 after his unwitnessed fall. Resident #2 denied pain, but the nurse noticed him moaning with facial grimacing. Resident #2 refused pain relief, and despite being educated on options, raised his voice, saying, I don't need anything. The nurse observed Resident #2 transferring himself and they had difficulty redirecting him. The Health Status Note dated 2/7/25 at 1:12 AM, indicated the nurse completed post-fall monitoring for Resident #2. Resident #2 denied pain, but the nurse noticed him moaning with facial grimacing. The nurse gave him PRN Tylenol, but it seemed ineffective. Resident #2 refused other pain relief and proved difficult to redirect. The Health Status Note dated 2/7/25 at 5:40 PM reflected Resident #2 continued to need 2 people to transfer and complained of right hip pain. The nurse gave him PRN Tylenol for the pain. Resident #2 had an Ortho appointment scheduled for the next week. (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	03/13/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0713 Level of Harm - Actual harm Residents Affected - Few	The Health Status Note dated 2/8/25 at 2:20 PM, indicated the CNA told the nurse that Resident #2 became extremely difficult while using the standing mechanical lift. Resident #2 complained of pain in both hips and the back, refusing to stand. The staff didn't feel safe transferring him that way. The nurse gave him PRN Tylenol, and the staff transferred Resident #2 to a wheelchair with a 2-person assist pivot (movement without twisting or rotating the spine or back). The staff felt they bore more of his weight than he did. Resident #2 picked at breakfast and wanted to use the bathroom. The staff asked the nurse to supervise since Resident #2 refused to stand while getting off the toilet. The staff used the standing mechanical lift, and Resident #2 became tearful during the transfer, saying his hips and back hurt. Afterwards Resident #2 rested in the recliner before the noon meal. The pivot transfer proved difficult, and Resident #2 refused to eat, saying he wanted to lie down. Due to his intense pain, the staff couldn't get Resident #2 up from the lying position. The nurse supervisor got notified. The nurse hadn't seen Resident #2 since the fall earlier in the week, and the situation marked a significant decline in his ability to transfer. The Health Status Note dated 2/8/25 at 2:38 PM, reflected the charge nurse notified the nurse Resident #2 couldn't bear any weight and complained of severe pain and he didn't have relief from the 1000 MG of PRN Tylenol. The nurse called Resident #2's wife, who agreed to send Resident #2 to the hospital if the doctor recommended it. The nurse received telephone orders to send Resident #2 to the emergency room (ER) for evaluation. The Health Status Note dated 2/9/25 at 6:52 AM, indicated the nurse called the ER for an update on Resident #2. The hospital reported they admitted Resident #2 for hypoxia and COVID-19. His X-rays showed a new fracture in the pubic rami. The Transfer/Discharge Report dated 2/8/25 at 2:40 PM, reflected the nurse documented Resident #2 felt restless and couldn't walk. Normally, Resident #2 could transfer with standby assistance from one person but couldn't do so that time. Resident #2 complained of severe pain in his lower back, both hips, and couldn't bear weight. Resident #2 stayed very restless and couldn't tolerate sitting on the toilet. Resident #2 fell last week. The History and Physical dated 2/8/25 at 8:40 PM identified Resident #2, went to the ER with complaints of lower back pain and right hip pain. Resident #2 didn't provide a clear history. According to the ER records, Resident #2 fell a week ago. For the last few days, the pain in his lower back and right hip worsened. He couldn't get up, transfer, or stand, though he usually could walk on his own. Due to the significant pain in his lower back and right hip, the staff eventually transferred him to the ER for evaluation. An X-ray of the hip showed acute (comes on suddenly and is usually caused by an injury or sudden illness)/subacute (a condition passed the acute phase but not quite long-term or chronic yet) fractures through the pubic rami (pelvis) on the right. On 3/6/25 at 2:30 PM, observed Resident #2 sitting in a reclining Geri chair (an extra cushioned wheelchair that allows a deeper recline allowing comfort, support, and adjustable features) with a red and yellow blanket over him, wearing glasses. He sat by the first-floor northwest nurses' station, with a staff member behind the station. Resident #2 had his feet elevated on the footrest of the reclining chair. On 3/10/25 at 5:30 PM, observed Resident #2 sitting in the television lounge with his feet elevated in a recliner. He couldn't remember the fall on 2/3/25. (continued on next page)

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	165072	A. Building B. Wing	03/13/2025

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 0713 Level of Harm - Actual harm Residents Affected - Few	Interview on 3/10/25 at 2:55 PM, Staff D, CNA, stated that on 2/3/25, they found Resident #2 on the bathroom floor with no witnesses. When Staff D and Staff E, CNA, helped Resident #2 off the floor, they tried to assist him back to his bed using a gait belt, Resident #2 said, it hurts, it hurts. Staff D explained that before the 2/3/25 fall, Resident #2 could transfer from the wheelchair to a couch in front of the fish tank on his own. After the fall, Resident #2 needed more help with transfers and complained of more pain in his hip and back. Staff D said the staff told the facility nurses about his increased need for assistance and the rise in pain. Interview on 3/10/25 at 3:15 PM, Staff E stated that on 2/3/25, someone found Resident #2 in the bathroom with no witnesses. When Staff E and Staff D helped Resident #2 off the floor with a gait belt and tried to assist him back to his bed, Resident #2 said, it hurts, it hurts. Staff E and Staff D laid Resident #2 down in bed. Staff E explained they worked with Resident #2 all week and noticed more facial grimacing and moaning when they tried to help him walk. The staff told the charge nurses about Resident #2 having more pain and needing more help with transfers and walking, but they told the staff to give Tylenol for the pain. Staff E felt Resident #2 should have gone to the hospital on 2/3/25 after his fall, since he kept saying it hurt to walk. Interview on 3/10/25 at 4:15 PM, Staff F, Licensed Practical Nurse (LPN), stated on 2/3/25, the staff found Resident #2 on the bathroom floor with no witnesses. Staff D and Staff E placed a gait belt around Resident #2 and tried to help him walk after they completed an assessment. Staff F said Resident #2 complained of pain in his back and posterior thigh area, saying it hurts, it hurts. Staff F didn't feel Resident #2 needed to go to the ER for an evaluation at that time. Staff F added they didn't work again until 2/7/25, and no one reported Resident #2 needed more assistance or experienced more pain with transfers. If Resident #2 had more pain and needed more help with transfers and pain medication on 2/5/25, Staff F confirmed that Resident #2 should have gone for an evaluation. Interview on 3/10/25 at 4:45 PM, Staff G, Registered Nurse (RN), stated after Resident #2 fell on [DATE], he complained of more pain in his right hip. However, Staff G didn't think it felt any different from the pain Resident #2 had when he admitted with his prior hip fracture. Staff G didn't feel Resident #2 needed to go out for an evaluation because of the increased pain or need for more help with transfers. Staff G said the House Supervisor needed to make that decision, not the floor charge nurse. Interview on 3/11/25 at 10:00 AM, Staff H, LPN, stated on 2/5/25, the floor staff told them Resident #2 needed more help with transfers, as he wouldn't transfer from the wheelchair to the couch, and complained of more pain in his right hip. Staff H said they informed the House Supervisor, who told them to call the orthopedic department to let them know Resident #2 had more pain and needed more help with transfers and ask if an x-ray might be helpful. Staff H finished their shift and didn't get a response from the orthopedic department. Staff H confirmed they should have insisted on sending Resident #2 to the ER for an evaluation due to his change in condition on 2/5/25. Staff H also mentioned that before the 2/3/25 fall, Resident #2 could transfer independently from the wheelchair to the couch. (continued on next page)

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F 0713 Level of Harm - Actual harm Residents Affected - Few	Interview 3/11/25 at 10:30 AM, Staff I, RN, stated that on 2/8/25, Resident #2 went to the ER because staff reported he needed more help with transfers and pain medication than usual. Staff I said the staff mentioned Resident #2 complained of pain while he sat on the toilet and grabbed his lower back and right hip. Staff I notified the house supervisor on call that day, and they sent Resident #2 out. Staff I added Resident #2 should have gone to theER on [DATE] or 2/5/25 when he needed more pain medication and extra help with transfers. Interview on 3/10/25 at 2:20 PM, Staff J, RN, stated that on 2/8/25 around 2:40 PM, the charge nurse reported Resident #2 needed a standing mechanical lift to transfer and he complained of more pain in his right lower back and right hip. They decided to send Resident #2 to the ER for an evaluation. Staff J confirmed that before 2/3/25, Resident #2 could transfer from the wheelchair to the couch in the front lobby on his own. Interview on 3/12/25 at 4:15 PM, the Assistant Director of Nursing (ADON) confirmed Resident #2 should have gone to theER on [DATE] after he complained of pain in the right side of his back and hip while he walked. Interview on 3/13/25 at 10:50 AM, the Director of Nursing (DON) and ADON confirmed after they reviewed Resident #2's clinical record that he needed to go to theER on [DATE] due his change in condition, as he required more pain medication and extra help with transfers. The Resident Accident or Incident policy from October 2022 stated that the facility's policy aimed to ensure the safety and well-being of all residents. Due to unexpected events, accidents, or incidents, a resident's well-being could get affected. All employees at the facility had the responsibility to respond properly and report the events.