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	02/24/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm 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** Based on observation, clinical record review, facility policy review, family, and staff interviews the facility failed to do a timely assessment on 1 of 3 residents reviewed (Resident #1). Resident #1 had a bruise on the right inner/outer thigh and hip area. The facility staff knew about the bruise on 2/13/26, and 2/14/26, which no staff assessed the area until 2/15/26 when the resident started to complain of pain. The facility reported a census of 150 residents.Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate impaired cognitive decisions. Resident #1 could understand others and others understood them. They had adequate hearing, and vision. Resident #1 required total staff assistance with toileting and substantial to maximal assistance with hygiene and dressing. The MDS included diagnoses of hypertension (a condition where blood consistently pushes hard against artery walls), Alzheimer's Disease, anxiety, depression, low back pain and history of falling.The Care Plan Focus initiated dated 2/4/25, indicated Resident #1 had a risk for skin breakdown and/or impaired wound healing related to age. The Interventions instructed the following:Observe skin with cares on shower days. Notify nurse/provider of concerns.Pressure reduction mattress to bed.Please assist Resident #1 with AM cares between 6:00 AM-7:00 AM every morning.Hip protectors to be worn at all times, may remove for cares, due to decline in health and bruising to right hip, Resident #1 is not wearing hip protectors at this time.The Risk Management form dated 2/15/26 at 10:40 AM, documented the staff called the nurse to Resident #1's bathroom. Resident #1 had a dark purple bruise extending from the right upper inner thigh to her right buttock. Resident #1 indicated they had discomfort when they transferred from the toilet to their wheelchair.The Health Status Note dated 2/15/26 at 10:40 AM, documented the staff called the nurse to Resident #1's bathroom. Resident #1 had a dark purple bruise extending from the right upper inner thigh to her right buttock. Resident #1 indicated they had discomfort when they transferred from the toilet to their wheelchair.The Incident Note labeled Late Entry dated 2/15/26 at 10:42 AM, documented, the nurse received a call from charge nurse, requesting them to come to Resident #1's room to see a bruise to their upper right thigh. Upon entering Resident #1's bathroom, they sat on the toilet, the staff stated they noticed the bruising and questioned if the bruise happened from a recent fall. A large bruise noted to the right upper thigh in various shades of purple, brownish outer parameters, and faded yellow on the top edges. The bruise extended from the upper thigh to the groin and around to the buttocks with some speckled bruising to the posterior right thigh. The top of the left thigh area had faint faded yellow bruising. The Incident Note labeled Late Entry dated 2/15/26 at 2:01 PM, documented the staff the nurse about Resident #1 in bed. Upon entering their room, observed Resident #1 in bed lying on her back. Once positioned it appeared Resident #1's right foot is approximately 2 inches shorter than the left and with the right knee turned outward. The thigh and knee had non-pitting edema present. When the nurse attempted gentle passive range of motion to (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's right leg, they winced. The nurse stopped and gently placed leg back to their previous position.The Facsimile dated 2/15/26, with no time, documented the staff noted a large bruise to Resident #1 right thigh when doing cares. The bruise had various stages of healing with yellowish and brownish purple edges, possibly from recent falls. Noted the right leg looked several inches shorter than the left as well on the right kneecap slightly facing outward. The note indicated the family knew. When offered to send Resident #1 for x-rays, the family declined, and stated they always had one leg shorter than the other. They didn't feel Resident #1 was not a candidate for further intervention and requested to just keep them comfortable at the facility.The untitled facility investigation file recorded on 2/15/26 at 10:42 AM, indicated Resident #1 had a large bruise to their right upper thigh in various shades of purple, with the outer parameters brownish, and the top edges faded a yellow color. The bruise extended from their upper thigh to the groin and around to the buttocks with some speckled bruising to the posterior right thigh. There is very faint faded yellow bruising to the top of the left thigh area. When staff assisted Resident #1 to stand, they said ow. The staff did a pivot transfer with 2 staff to their wheelchair. Resident #1 didn't have complaints of pain once in wheelchair. The file documented an interview with Staff A, Certified Nursing Assistant (CNA), on 2/19/26. Staff A stated on 2/13/26, Resident #1 had purple/green swelling on the side of her hip and also under her buttocks. Staff A described them as noticeable but not too big or too small. The facility's interview with Staff B, CNA, stated, when they worked on 2/14/26, they told the nurse about the bruises at 8:45 AM. Resident #1 didn't have any signs of pain. On 2/15/26, Staff B went into the room with another staff member, Resident #1 yelled every time they attempted to move her to transfer. They called the nurse to verify what they saw and Resident #1's emotional state. The interview with Staff C, CNA, documented, they worked on 2/13/26. Staff C reported it took 2 of them and a gait belt to transfer her to the restroom. While in the bathroom, Staff C explained they noticed a bruise. The interview with Staff D, Licensed Practical Nurse (LPN), stated on 2/15/26, Staff B, mentioned Resident #1 had a bruise and they went to look at it on 2/15/26. Staff D admitted they didn't look at the bruise on 2/14/26, as it slipped their mind.On 2/17/26 at 4:30 PM, observe a bruise, in multiple stages, on Resident #1's right hip area, extending from the thigh/hip area down behind the right knee.On 2/17/26 at 2:30 PM, Resident #1's family member said they saw the bruising on 2/15/26 from the top of Resident #1 right hip/thigh area, across her buttocks and down behind the right knee. On 2/24/26 at 12:30 PM, the Assistant Director of Nursing (ADON), acknowledged Staff D failed to assess the bruise on Resident #1 right thigh/hip area on 2/14/26 when was the staff first alerted them. The ADON reported they expected the licensed staff to follow through with any change in resident conditions, bruising, falls, or anything out of the norm and do an assessment.On 2/24/26 at 1:30 PM, the Director of Nursing (DON) stated they expected the nursing staff to follow the procedure/policies for unusual occurrence and do an assessment as warranted.The Skin Program reviewed 2/13/26, instructed staff to use risk management for identification of skin issues. A member of the administrative skin team would complete a follow-up observation and initiate measures to prevent further skin issues. Weekly skin/wound progress notes will be completed until the area is resolved.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and facility policy and procedures, the facility failed to implement interventions to prevent weight loss and implement adequate hydration for 1 of 3 residents reviewed for weight loss and hydration (Resident #2). The facility identified a census of 150 residents.Findings include:Resident #2's Minimum Data Set (MDS) assessment dated [DATE], identified short- and long-term memory problems with severely impaired decision-making abilities. Resident #2 required supervision for eating/drinking. The MDS listed Resident #2 at 230 pounds with no weight loss. The MDS included diagnoses of Alzheimer's Disease, Parkinson's and depression.The Care Plan Focus initiated dated 4/13/23, indicated Resident #2 had an activity of daily living (ADL) self-care performance deficit related to Alzheimer's/Parkinson's. The Interventions instructed the following:a. If you notice Resident #2 not eating or distracted at meal times, please sit with them and offer to assist them.b. Avoid over eating. Provide small frequent meals rather than 3 large ones.c. Provide house supplement as ordered.d. Registered Dietician to evaluate and make diet change recommendations as needed.e. Weigh weekly or as directed. The Electronic Health Record for the weight summary, revealed the following weights for Resident #2:a. On 10/27/25, weighed 234.5 poundsb. On 11/3/25, weighed 231.5 poundsc. On 11/10/25, weighed 229 poundsd. On 11/17/25, weighed 222.1 poundse. On 11/24/25, weighed 220.5 poundsf. On 12/1/25 weighed 218.5 pounds, a 5% weight declineg. On 12/11/25 weighed 217.4 pounds, a 5% weight declineThe Behavior Note dated 10/28/25 at 1:16 PM, documented as Resident #2 sat at the assisted table, they refused to have staff fill liquids in two handled cups and pushed glasses away from him and taking their tablemate's glass of water. After the staff poured Resident #2 liquids, they took half of the liquids, went to his room, and he poured them on the floor and the table. When the staff attempted to assist Resident #2, he refused assistance and fed himself. The Behavior Note dated 11/12/25 at 10:05 PM, documented, Resident #2 refused his house supplement. He only ate bites for supper and refused to allow staff to assist him with feeding. Resident #2 pushed the staff's hand away during any attempt to help him.The Behavior Note dated 11/26/25 at 10:12 PM, documented Resident #2 refused his afternoon house supplement. At supper, he refused all food offered to him. When the staff offered Resident #1 the casserole, he clamped his mouth shut. When offered a meat sandwich, he refused it.The Health Status Note date 11/30/25 at 1:07 PM, documented the staff attempted to assist Resident #2 at breakfast and noon meal. Resident #2 pushed his food away and pushed himself back in the wheelchair. Resident #2 refused to open their mouth and dumped his liquids on the floor.The After Visit Summary dated 12/11/25 at 10:51 AM, instructed Resident #2 needed 2 liters of water per day. In addition, he would need one-to-one (1-1) assistance for water intake as well as for diet orders.Resident #2's Electronic Health Record reviewed 2/18/26 at 4:03 PM revealed from 12/11/25 - 2/18/26, the Point of Care Response History for fluids received, lacked documentation Resident #2 received 2 liters of water per day. On 2/17/26 at 2:00 PM, observed Resident #2 sitting in a wheelchair, lips, gums, tongue appeared moist with no dryness noted.On 2/18/26, observed the noon meal from 11:15 AM - 11:55 AM, Resident #2 had a double handled mug filled with a clear liquid and another double handled mug filled with a brown liquid. Staff assisted Resident #2 with eating and drinking. At 12:30 PM, noted Resident #2 drank most of his liquids and left a few bites of lunch on the plate.On 2/19/26 at 11:01 AM, the Director of Nursing (DON) acknowledged Resident #2's clinical record lacked documentation of him receiving 2 liters of water every day. They added the 2 liters of water to the Treatment Administration Record for the nurses to document his intake of water.On 2/24/26 at 1:40 PM, the DON confirmed the clinical record lacked documentation of appropriate interventions to keep Resident #2 from an unintended weight (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	loss.The Policy and Procedure for Interventions for Unintended Weight Loss dated 5/21/23, indicated the facility would identify and monitor unintended weight loss or gradual weight loss, so the staff could implement appropriate and individualized interventions. Th policy reflected it was appropriate for individuals who have unintended weight loss and/or a malnutrition diagnosis.