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	12/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, record review, and staff interviews the facility failed to ensure the windows for 2 of 2 bird aviaries were maintained in between routine cleanings and kept free of excessive bird feces. The facility reported a census of 145 residents. Findings include: Observation on 12/11/25 at 10:45 AM the Memory Care bird aviary consisted of 8 windows. All windows had multiple areas with white bird feces on it. Observation on 12/11/25 at 10:40 AM the Dining Room bird aviary consisted of 8 windows. All windows had multiple areas with white bird feces on itReview of the Aviary Service Checklist dated 7/30/25 documented the Memory Care aviary and Dining Room aviary last cleaned on 7/30/25.In an interview on 12/11/25 at 11:53 AM with the Administrator revealed the facility has a contracted a company from another state that provides quarterly cleaning to the aviaries. She informed in-between quarterly cleanings no one cleans or goes inside the aviary unless something urgent need to be done.

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review, staff interview, and policy review the facility failed to ensure the Medical Director attended the Quality Assessment and Assurance (QAA) meetings quarterly. The facility reported a census of 145 residents. Findings include:The Quality Assurance (QA) Meeting Records provided by the facility revealed the Medical Director attended the QA meetings on 5/21/25 and 7/28/25 but not on the 1st quarterly meeting (3/20/25) or the 4th quarterly meeting (10/15/25). The facility failed to have the required members present at least quarterly for the facility's QA meetings.In an interview on 12/11/25 at 12:00 PM the Administrator reviewed the Quality Assurance Meeting Records and acknowledged that the Medical Director was not present at the 3/20/25 and 10/15/25 QA meetings. On 12/11/25 at 12:00 PM the Administrator stated that she is familiar with the QA committee meeting quarterly and the need for members to be present. In an interview on 12/11/25 at 12:00 PM the Director of Nursing (DON) reviewed the Quality Assurance Meeting Records and acknowledged the Medical Director didn't attend the QA meetings on 3/20/25 and 10/15/25.On 12/11/25 at 12:15 PM the Director of Nursing (DON) stated she expected the Medical Director to be present during the quarterly meetings. Review of the Annual Quality Assurance Performance Improvement (QAPI) Plan dated 2025, directed the QAPI Committee meets minimally bi-monthly with their Medical Director and will include and address any facility care concerns. The QAPI Committee may decide to meet on a quarterly basis rather than bi-monthly, or monthly. The DON or designee will be responsible for the maintaining of meeting minutes and activity.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and policy review, the facility failed to notify resident's representative in advance of the risks and benefits of a psychotropic medication, the treatment alternatives or other options and was able to choose the option the representative prefers for 1 of 5 residents reviewed (Resident #1). The facility reported a census of 145 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 0, indicating severely impaired cognition. The MDS included diagnoses of dementia, diabetes and respiratory failure. Physician order dated 11/17/25 for quetiapine (antipsychotic medicine that works in the brain) by mouth once daily as needed for aggression and agitation. Resident #1's Electronic Health Record (EHR) lacked documentation of notifying the resident's representative in advance of the risks and benefits of the medication, treatment alternatives or other options and let them choose the option they prefer prior to administering the medication.Resident #'1's Medication Administration Record (MAR) for November 2025 documented Resident #1 received the quetiapine 5 times that month. The MAR for December 2025 documented Resident #1 received quetiapine once. On 12/11/2025 at 10:18 AM the Director of Nursing (DON) reported they facility didn't do a consent with the family for quetiapine prior to giving. The DON reported staff are to speak with the family about risks vs benefits and document it.The undated facility policy titled Antipsychotic Medication Used lacked direction on notifying the resident or resident representative in advance of the risks and benefits of a psychotropic medication, the treatment alternatives or other options and was able to choose the option the resident or representative prefers.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** ˆBased on record review, staff and family interviews, and policy review the facility failed to ensure 1 of 2 residents personal belongings were retained in the facility and returned to the family after their death (Resident #159). The facility reported a census of 145 residents.Facility staff implemented immediate interventions on [DATE] and completed on [DATE] through the following actions:a. Discussion with facility staff on where the missing items went and identifying a miscommunication occurred with facility staff.b. Offered the family to replace the items at the facilities expense.The deficient practice was identified as past non-compliance singular event as of [DATE], the items were thrown away due to miscommunication prior to the survey, and financial compensation was offered to the family. Findings include:The Facility Death Record for Resident #159 documented she died on [DATE] at 1:50 PM.The Communication - with family/NOK/POA note dated [DATE] at 11:34 AM indicated the family hadn't finished with the room. The Social Worker read the note wrong and alerted housekeeping to clean the room. The family planned to come back to get other belongings. Unfortunately, the facility cleaned the room and removed the belongings. The Administrator and Social Worker apologized to the daughter.The Communication - with family/NOK/POA note dated [DATE] at 11:51 AM reflected Resident #159's Daughter called and expressed concerns of Resident #159's items being thrown before family could go through them. In an interview on [DATE] at 2:56 PM Resident #159's Daughter reported the facility Social Worker and Housekeeper had a misunderstanding and threw away the following things of her mom's personal items before they could come and pick them up:1. Family Picture in frame2. Pictures of when she was young on a tackboard3. Knitted last name doily4. Clothing5. Wall hanging with a saying on it6. Tie fleece blanket mauve and blue with [NAME] In an interview on [DATE] at 11:54 AM the Administrator explained they informed Resident #159's Daughter on [DATE] they would replace and pay for anything the facility accidently destroyed. She also reported they do not complete an inventory list as they are hard to keep up to date when families bring in or take-home items routinely throughout their stay at the facility. In an interview on [DATE] at 12:13 PM the Director of Nursing (DON) verbalized they offered financial compensation to the family, but they haven't heard anything. Review of an untitled and undated statement by the facility's Pastor reported he spoke with Resident #159's family on [DATE] at approximately 4:00 PM and expressed apologies for accidently throwing away personal items and reiterated the facility would provide financial compensation for the items. Review of an untitled statement dated [DATE] by the facilities Chief Executive Officer indicated on [DATE] he gave the directive to staff the facility would reimburse the family for whatever items they intended on keeping. Review of an undated Personal Property policy instructed the following: A representative of the admitting office advises the resident, prior to or upon admission, of the types and amount of personal clothing and possessions that the resident may keep in his or her room.The facility promptly investigates any complaints of misappropriation or mistreatment of resident property.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and policy review, the facility failed to submit a Preadmission Screening and Resident Review (PASRR) for 1 of 2 residents with new mental health diagnoses (Resident #22). The facility reported a census of 145 residents.Findings include:Resident #22's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of anxiety, depression and psychotic disorder.The Electronic Health Record (EHR) listed a generalized anxiety disorder diagnosis added 5/14/19. In addition, an unspecified moderate dementia with other behavioral disturbance and unspecified psychosis diagnoses added 10/9/23.The Physician's Orders indicated that quetiapine (an antipsychotic medication) 25 milligrams two times daily started 2/7/23.Resident #22's Level I PASRR dated 10/21/18 lacked diagnoses of generalized anxiety disorder, unspecified moderate dementia with other behavioral disturbance and unspecified psychosis.Resident #24's clinical record lacked a PASRR after 10/21/18. In an interview on 12/10/25 at 2:43 PM Staff D, Social Worker (SW), stated that the last PASRR Level I was done for Resident #22 on 10/21/18. She would submit a new PASRR if significant medication changes or mental wellbeing would change. When asked about a new diagnosis of generalized anxiety disorder that was added 5/14/19, she stated she should have done one. When questioned about a new antipsychotic medication quetiapine on 2/7/23, she stated it would be on a case-by-case basis. When questioned about new diagnoses of moderate unspecified dementia and unspecified psychosis on 10/9/23, she again stated it would be on a case-by-case basis. She then added that based on or conversation that she would be doing a new one now.In an interview on 12/11/25 at 9:30 AM the Assistant Director of Nursing (ADON) stated that they do not have a policy on PASRR, and they follow the guidelines.In a document titled Iowa PASRR Program revised on 2/19/25, it indicated the PASRR evaluation must occur prior to admission, whenever a prior approval is expiring, and whenever a resident experiences a significant change in status.