

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/18/2026
NAME OF PROVIDER OR SUPPLIER Good Shepherd Home		STREET ADDRESS, CITY, STATE, ZIP CODE 725 Columbus Ave Fostoria, OH 44830	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and review of the facility policy, the facility failed to ensure medications were properly stored, labeled, and dated. This had the potential to affect all 80 residents residing in the facility. The facility census was 80. Review of the medical record for Resident #73 revealed an admission on [DATE]. Diagnoses included allergic rhinitis, hypertensive heart disease with heart failure, and anxiety disorder. Review of the physician's order dated 05/06/26 revealed an order for ipratropium bromide nasal solution 0.03 percent (%) for two sprays in both nostrils every 24 hours as needed for rhinitis related to allergic rhinitis. Review of the medical record for Resident #71 revealed an admission on [DATE]. Diagnoses included hyperlipidemia, major depressive disorder, and anxiety. Review of the physician's orders dated 11/08/23 revealed an order for fluticasone propionate nasal suspension 50 micrograms per actuation (mcg/act) for one spray in each nostril one time a day for nasal congestion. Review of the medical record for Resident #11 revealed an admission on [DATE]. Diagnoses included acute kidney failure, schizophrenia, and depression. Review of the physician's orders dated 10/04/24 revealed an order for Flonase allergy relief nasal suspension 50 mcg/act for one spray in both nostrils one time a day for allergies. Review of the medical record for Resident #37 revealed an admission on [DATE]. Diagnoses included acute-angle-closure glaucoma, hypertensive heart disease, and aphasia. Review of the physician's order dated 10/31/25 revealed an order for latanoprost ophthalmic solution 0.005% to instill one drop in both eyes at bedtime related to acute-angle-closure glaucoma. Observation on 05/12/26 at 9:17 A.M. of the 100 hall medication cart revealed Resident #73's ipratropium bromide nasal solution was opened and not dated, Resident #71's fluticasone nasal spray was opened and not dated, Resident #11's fluticasone nasal spray was opened and not dated, and Resident #37's latanoprost ophthalmic solution was unopened with a label reading to, Keep refrigerated until opened. Observation on 05/12/26 at 9:23 A.M. of the 100-hallway medication storage room revealed a bottle of tuberculin purified protein derivative (an intradermal aid in the detection of infection with Mycobacterium tuberculosis) with an open date on 02/21/26. Interview on 05/12/26 at 9:23 A.M. with Registered Nurse (RN) #44 confirmed Resident #73's ipratropium bromide nasal solution was opened and not dated, Resident #71's fluticasone nasal spray was opened and not dated, Resident #11's fluticasone nasal spray was opened and not dated, and Resident #37's latanoprost ophthalmic solution was as not opened with a label reading, Keep refrigerated until opened. Further interview with RN #44 confirmed the tuberculin purified protein derivative had an open date of 02/21/26 and the solution should be thrown away after 30 days, and that all nasal sprays and eye drops that were opened were to be dated. Review of the facility policy for medication storage, dated 02/2024, revealed all medications (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 365963	Facility ID: 365963 If continuation sheet Page 1 of 14

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and policy review, the facility failed to ensure food was prepared and stored in a safe and sanitary manner. This affected all 77 residents who received food from the kitchen. The facility identified three (#4, #60, and #61) residents received nothing by mouth. The facility census was 80. Findings included: 1. Observation of the facility kitchen on 05/11/26 at 7:45 A.M. revealed Dietary Aide (DA) #195 was in the kitchen pouring drinks and assisting with breakfast preparation. DA #195 was noted to have a long beard and hair. His hair was covered with a hairnet, but his beard was not covered. Interview with [NAME] #190 on 05/11/26 at 7:50 A.M. verified DA #195 failed to wear a beard protector while preparing food for residents. Review of the facility policy titled, Personal Hygiene, dated 05/01/19, revealed beards or any body hair that may be exposed (i.e., arms) must be covered. 2. Observation on 05/13/26 at 10:52 A.M. revealed a plastic scoop was imbedded in the flour bin. Interview with [NAME] #221 on 05/13/26 at 10:53 A.M. confirmed the flour scoop was to be stored outside of the bin and not inside of the flour. Review of the undated facility policy titled, Scoop and Ladle Storage Policy, revealed scoops may be stored outside the product in a clean holder or inside the product with the handle extending out of the food. Scoops may not be buried completely in food products.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, review of infection control documents, staff interview, and review of facility policy, the facility failed to ensure resident infections were adequately tracked for potential trends, failed to ensure residents with wounds were in enhanced barrier precautions, and failed to ensure resident equipment used to inhale medications were kept and stored in a sanitary manner. This had the potential to affect all 80 residents residing in the facility. The facility census was 80. Findings include: 1. Review on 05/18/26 at 9:00 A.M. of the facility's infection control surveillance plan for April 2026, revealed there was no surveillance of the bacteria found in the infections identified. It was noted there were 13 urinary tract infections (UTIs), one respiratory infection, and one skin infection. Interview on 05/18/26 at 9:20 A.M. with the Director of Nursing (DON), who also served as the Infection Preventionist (IP), confirmed there was no tracking of the bacteria found in the infections identified for April 2026, and furthermore, the DON could not answer how the facility kept track of trends other than mapping. 2. Review of the medical record for Resident #2 revealed an admission on [DATE]. Diagnoses included unspecified dementia, major depressive disorder, and normal pressure hydrocephalus. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had severe cognitive impairment. Further review of revealed Resident #2 was dependent on staff for activities of daily living (ADLs). Review of the physician's orders for Resident #2 revealed an order on 04/23/26 to cleanse the resident's buttocks with soap and water and apply triad to bilateral buttocks twice a day and as needed. Further review of the physician's orders revealed an order on 02/18/26 to skin prep the resident's erythema and cover with bordered dressing and offload per facility protocol to the right hip area. Review of Resident #2's active physician orders revealed no orders for enhanced barrier precautions (EBP). Review of the wound care notes revealed Resident #2 had been seen by wound care since 03/14/23 and was last seen on 05/07/26 for a stage three wound (full-thickness skin damage) to the coccyx. Observation on 05/11/26 at 9:00 A.M. revealed Resident #2's bedroom did not have an EBP sign on the door and also did not have personal protective equipment (PPE) available inside or outside of the room. Interview on 05/11/26 at 2:52 P.M. with Licensed Practical Nurse (LPN) Unit Manager #173 confirmed Resident #2 did not have an order, PPE readily available, or signage indicating the resident required EBP for her coccyx wound. 3. Record review for Resident #1 revealed the resident was admitted to the facility on [DATE] with (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	diagnoses including congestive heart failure, vascular dementia, paranoid schizophrenia, diabetes mellitus type two and chronic respiratory failure. Review of a physician order dated 03/10/26 revealed Resident #1 was ordered levalbuterol inhalation nebulization solution 1.25 milligrams per three (3) milliliters for one dose inhaled orally by nebulizer three times a day for wheezing/shortness of breath. Observation on 05/11/26 at 12:05 P.M. revealed Resident #1 was sitting in the recliner and the nebulizer machine was sitting on a nightstand with the medication chamber attached to the mask and tubing. The medication chamber had residue from a previous medication treatment. Interview on 05/11/26 at 12:09 A.M. with Licensed Practical Nurse (LPN) #244 revealed Resident #1's medication chamber was not cleaned, and the mask, tubing, and chamber were not covered. Review of facility policy for nebulizer therapy, dated 02/2025, revealed nursing staff should disassemble and rinse the nebulizer with sterile or distilled water and allow to air dry. Once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observation, staff interview, review of the activities calendar, and review of the facility policy, the facility failed to implement the activities calendar as scheduled and provide activities to meet resident needs. This affected 37 (#41, #28, #31, #17, #69, #64, #77, #3, #70, #49, #80, #51, #56, #39, #15, #82, #5, #32, #48, #36, #50, #62, #52, #38, #30, #24, #29, #22, #21, #9, #58, #20, #83, #76, #65, #79, and #2) of 37 residents who resided in the memory care unit. The facility census was 80. Findings include: Review of the activities calendar for the memory care unit revealed every day at 9:30 A.M. there was an activity called, Morning Greetings. Repetitive activities were noted on the same day each week. Further review of the activities calendar revealed there were no activities offered past 2:30 P.M. with the exception on 04/07/26 for music time at 3:15 P.M. Observation on 05/11/26 at 9:30 A.M. of the memory care unit revealed there was no activity completed. Observation on 05/11/26 at 10:15 A.M. revealed Activities Director (AD) #142 painting some of the female resident's nails; however, no male residents were observed receiving nail care. Interview on 05/11/26 at 10:15 A.M. with AD #142 confirmed there were no activities completed at 9:30 A.M. AD #142 further stated she was doing the activity called Manicure Hour, which consisted of painting nails, and sometimes filing resident's nails. AD #142 stated not all residents are asked if they want their nails done, and stated the male residents can have their nails filed. Observation on 05/12/26 at 9:30 A.M. of the memory care unit revealed there was no activity completed as scheduled and 16 residents were sitting in the common area with a movie on. Observation on 05/12/26 at 10:25 A.M. revealed an activity called, Devotion with the Chaplin was in progress with residents noted sitting in recliner chairs, and a Chaplin put on religious music and singing. Further observation on 05/12/26 at 2:05 P.M. of the memory care unit revealed two residents and Case Manager (CM) #146 sitting at a table with a puzzle in front of them. One resident was sleeping and the other resident was not actively participating in the activity. The posted activity was called, Puzzle Time, and there were 22 residents sitting in the common area with the television on. Interview on 05/12/26 at 2:05 P.M. CM #146 revealed she did not work for the facility and was at the facility to do one-on-one behavioral health with the residents. Interview on 05/12/26 at 2:08 P.M. with Licensed Practical Nurse (LPN) Unit Manager #173 revealed CM #146 did not work at the facility. LPN Unit Manager #173 further confirmed that residents on the memory care unit were not offered the scheduled activities that week because the regular activity aid was doing certified nurse aide (CNA) training. Observation on 05/13/26 at 10:11 A.M. of the memory care unit revealed residents sitting at two tables. There were six residents placing stickers on an umbrella and one resident was sleeping. AD #142 went back and forth assisting residents with completing the activity. Observation on 05/14/26 at 9:30 A.M. of the memory care unit revealed there was no activity completed as scheduled and 17 residents were sitting in the common area with a movie on. Review of the facility policy for activities, dated 04/2025, revealed activities would be designed with the intent to enhance the resident's sense of well-being, belonging, and usefulness, create opportunities for each resident to have a meaningful life, promote or enhance physical activity, promote or enhance cognition, promote or enhance emotional health, reflect resident's interests and age, reflect cultural and religious interests of the resident's, and reflect choices of the resident's. Activities were to include, indoor and outdoor activities, and activities away from the facility. This deficiency represents non-compliance investigated under Complaint Number 2666521.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, medical record review, staff interview, and policy review, the facility failed to ensure proper notifications were made when a resident changed rooms. This affected one (#89) of one residents reviewed for room changes. The facility census was 80. Findings include: Record review for Resident #89 revealed the resident was admitted to the facility on [DATE] with diagnoses including pressure ulcer of the sacral region, history of malignant neoplasm of the rectum, vascular dementia, and congestive heart failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #89 had moderately impaired cognition, was assessed to require supervision with toileting and dressing, and required moderate assistance with bathing. Review of the care plan dated 02/05/26 revealed Resident #89 had an activities of daily living (ADLs) self-care performance deficit related to vascular dementia, chronic pain, shortness of breath, fibromyalgia, spondylosis, intervertebral disc degeneration, and fatigue. Review of nursing notes revealed Resident #89 moved from room [ROOM NUMBER] to room [ROOM NUMBER]. There was no documentation in the medical record of the facility notifying the resident's Power of Attorney (POA) or physician of the room change. Observation on 05/11/26 at 9:45 A.M. revealed Resident #89 was not residing in room [ROOM NUMBER]. A blanket was laid in front of the door with a laundry cart in front of the door. Interview on 05/11/26 at 9:47 A.M. with Licensed Practical Nurse (LPN) #244 revealed Resident #89 was moved to room [ROOM NUMBER]. Interview on 05/11/26 at 10:13 A.M. with the Director of Nursing (DON) revealed Resident #89 was moved to deep clean the room and will be moving back later today or tomorrow. Interview 05/12/26 at 11:10 A.M. with Plant Operations (PO) Staff #241 revealed Resident #89 was moved to room [ROOM NUMBER] on 05/10/26 due to bed bugs. Interview on 05/12/26 at 12:10 A.M. with Operations Director (OD) #229 verified the facility did not notify Resident #89's POA or physician of the resident's room change. Interview on 05/14/26 at 3:12 P.M. with the DON verified facility did not notify the resident's POA or physician of Resident #89 room change. Review of the facility policy for notification of change, dated 10/24, revealed the facility will notify the physician and resident representative when there is a change of room or roommate assignment.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, medical record review, staff interview, and review of a facility policy, the facility failed to ensure resident rooms were in good repair. This affected one (#5) of one residents reviewed for environment. The facility census was 80. Findings include: Review of the medical record for Resident #5 revealed a care conference was held on 03/11/26. It was noted the wall behind the resident's chair was getting bad due to the chair hitting it, and maintenance would fix it and order a tool to place behind the chair. Observation on 05/11/26 at 10:56 A.M. of Resident #5's bedroom revealed a large area behind the recliner chair that had chipped drywall and large scratches without paint. Interview on 05/12/26 at 2:39 P.M. with Plant Operations (PO) Staff #241 revealed he was unaware there was an issue with Resident #5's bedroom and confirmed the areas were in bad repair. PO Staff #241 further stated there was not a device to place behind the chair to protect the wall. Review of the facility policy for resident environmental quality, dated 02/2025, revealed the facility will maintain a sanitary and comfortable environment for residents, staff and the public.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, resident and staff interview, and review of a facility policy, the facility failed to ensure adequate care was provided for residents dependent on staff for finger nail care. This affected two (#22 and 26) of two residents reviewed for activities of daily living. The census was 80. Findings include: 1. Review of the medical record for Resident #22 revealed an admission on [DATE]. Diagnoses included cerebrovascular disease, epilepsy, and anxiety disorder. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 had severe cognitive impairment. Further review of the MDS assessment revealed Resident #22 required substantial assistance with personal hygiene. Review of the care plan dated 12/05/24 revealed Resident #22 had an activities of daily living (ADLs) self-care performance deficit related to vascular dementia. Interventions included Resident #22 required substantial assist with personal hygiene. Observation on 05/11/26 at 10:18 A.M. revealed Resident #22 sitting in her recliner chair in the common area. Resident #22 had just completed the an activity involving manicures with Activities Director (AD) #142. Further observation of Resident #22's finger nails revealed a large amount of build-up under all of her nails. Interview on 05/11/26 at 10:21 A.M. with Certified Nurse Aide (CNA) #144 confirmed there was a large amount of build up under all of Resident #22's finger nails. CNA #144 stated hospice staff were who completed ADL care for Resident #22 during her showers. CNA further confirmed anyone can complete nail care to residents who needed it. Interview on 05/11/26 at 10:27 A.M. with AD #142 revealed sometimes activities will complete nail care, but the resident activity involving manicures was just filing the residents' nails and applying nail polish. AD #142 confirmed she did not clean under Resident #22's finger nails. 2. Review of Resident #26's medical record revealed an admission date of 04/28/26. Diagnoses included acute kidney failure, hemiplegia, and Parkinson's disease. Review of Resident #26's admission MDS assessment dated [DATE] revealed the resident had an intact cognition and was dependent on staff for personal hygiene. Review of Resident #26's most recent care plan dated 05/11/26 revealed he was dependent on staff for personal hygiene and required substantial assist with oral care. Review of Resident #26's shower records revealed he received a shower on 04/29/26, 04/30/26, 05/01/26, 05/02/26, 05/04/26, 05/05/26, 05/06/26, 05/06/26, 05/07/26, 05/08/26, 05/09/26, 05/10/26, 05/11/26, 05/12/26, and 05/14/26. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #26 on 05/11/26 at 9:49 A.M. revealed he had not had his finger nails trimmed since admission and would like them trimmed. Observation of Resident #26's fingernails on 05/11/26 at 9:49 A.M. revealed the nails were grown out and extending approximately one-half an inch over his fingertips. Observation and interview with Resident #26 on 05/14/26 at 10:34 A.M. revealed the resident was sitting in his recliner dressed for the day and his hair was damp. His finger nails continued to be long and uncut. The resident confirmed his nails were long and he wished to have them cut. Interview with CNA #107 on 05/14/26 at 10:37 A.M. revealed Resident #26 had a shower that morning. Further interview with CNA #107 on 05/14/26 at 10:42 A.M. revealed the nurse aid verified Resident #26's finger nails were in need of cutting, but only nurses could provide that task since the resident was diabetic. Review of the facility policy titled, Activities of Daily Living (ADLs), dated 04/2024, revealed care and services will be provided for the following activities of daily living including bathing, dressing, grooming, and oral care. A resident who was unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 medical record review and staff interview, the facility failed to ensure orders and interventions were in place to address a resident's need for leg braces. This affected one (#59) of one residents reviewed for brace devices. The census was 80. Findings included: Review of Resident #59's medical record revealed an admission date of 06/28/25. Diagnoses included displaced comminuted fracture of the shaft of the right femur, intellectual disabilities, epilepsy, and anxiety. Review of Resident #59's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition and participated in physical and occupational therapy. Review of Resident #59's current comprehensive care plan revealed the plan did not address the resident's need or care related to knee braces. Review of Resident #59's nurses note dated 03/25/26 revealed the resident was present at his care conference. The resident's family was questioning the need for the new bilateral knee braces. The nurse spoke to physical therapy, and they confirmed it was mandatory to wear the braces and Resident #59 would require adjustments throughout the day for proper placement. Review of Resident #59's nurses note dated 03/26/26 revealed the nurse discussed with the resident regarding the podiatrist orders for physical therapy, and she would call his family regarding insurance refusal to cover therapy to treat his right foot. The nurse gave education and instruction regarding applying his new bilateral knee brace and having them adjusted if slipping. The resident voiced understanding the braces were mandatory for him to wear. Interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 05/14/26 at 9:10 A.M. revealed Resident #59 had leg braces he applied every morning. The staff members stated the resident's family requested he put the braces on by himself, which he wore for knee strength. Review of Resident #59's current physician orders revealed it was silent regarding an order regarding bilateral knee braces. Interview with the DON on 05/14/26 at 3:51 P.M. revealed Resident #59 really did not wear leg braces and they were elastic sleeves. The DON stated the resident applied them when he wished to wear them and took them off on his own. The DON stated the devices did not require a physician's order nor was a care plan needed or developed for them. Interview with Therapy Director (TD) #247 on 05/18/26 at 10:17 A.M. revealed he was unaware if there was a physician's order for Resident #59's knee braces. TD #247 stated the resident was independent of applying and removing the braces, but they needed adjusting periodically. TD #247 revealed he ordered the resident new braces two months ago due to the fasteners being worn out.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/18/2026
NAME OF PROVIDER OR SUPPLIER Good Shepherd Home		STREET ADDRESS, CITY, STATE, ZIP CODE 725 Columbus Ave Fostoria, OH 44830	
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 Note: The nursing home is disputing this citation.	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** Based on medical record review and and staff interview, the facility failed to ensure fall prevention measures were implemented for residents following a fall episode. This affected two (#1 and #78) of six residents reviewed for accidents. The facility census was 80. Findings include: 1. Record review for Resident #1 revealed the resident was admitted to the facility on [DATE] with diagnoses including congestive heart failure, vascular dementia, paranoid schizophrenia, diabetes mellitus type two, and chronic respiratory failure. The resident was admitted to hospice care on 03/24/26. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had intact cognition and was assessed to require moderate assistance with toileting, bathing, and dressing. Resident #1 also received antipsychotic, antibiotic, diuretic, antiplatelet, anticonvulsant, hypoglycemic, and opioid medications during the assessment look back period. Review of the care plan dated 03/10/26 revealed Resident #1 was at high risk for falls related to gait/balance problems, incontinence, unspecified convulsions, psychoactive drug use, and a history of falls in the last 30 days. Review of nursing notes revealed Resident #1 had an unwitnessed fall on 05/07/26 due to trying to stand up out of bed to go to the bathroom but ended up slipping out of bed onto the floor. Resident #1 received a skin tear measuring one (1) centimeter (cm) long by one cm wide. A non-adherent dressing and kerlix were placed and no fall interventions were implemented. 2. Record review for Resident #78 revealed the resident was admitted to the facility on [DATE] with diagnoses including chronic congestive heart failure, Parkinson's disease, and respiratory failure. Review of the MDS assessment dated [DATE] revealed Resident #78 had moderately impaired cognition was assessed to require moderate assistance with toileting, bathing, and dressing, and received diuretic, opioid, and hypoglycemic medications during the assessment look back period. Review of nursing notes revealed Resident #78 had an unwitnessed fall with facial injuries. Further review revealed no fall interventions were implemented. Interview on 05/13/26 at 3:40 P.M. with the Director of Nursing (DON) revealed no fall precautions were implemented for Resident #1 or Resident #78 following a fall.		

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NAME OF PROVIDER OR SUPPLIER Good Shepherd Home		STREET ADDRESS, CITY, STATE, ZIP CODE 725 Columbus Ave Fostoria, OH 44830	
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and facility policy review, the facility failed to ensure gastric contents were replaced when verifying placement of a feeding tube. This affected one (#44) of one residents reviewed for feeding tubes. The census was 80. Findings include: Review of the medical record for Resident #44 revealed an admission on [DATE]. Diagnoses included gastro-esophageal reflux disease without esophagitis, multiple sclerosis, and cerebral ischemia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 had cognitive impairment and was assessed with a percutaneous endoscopic gastrostomy (PEG) tube (a soft, flexible feed tube inserted through the abdomen directing into the stomach to deliver nutrition, fluids, and medication). Review of the care plan dated 10/29/24 revealed Resident #44 required tube feeding related to inadequate nutritional intake due to poor appetite, swallowing problems, dysphagia, weight loss, and anemia. Interventions included Resident #44 required total assistance with tube feeding and water flushes. Review of the physician's orders for Resident #44 revealed an order on 10/25/23 to flush with 30 cubic centimeters (cc) before and after medications were given per PEG tube. Observation on 05/12/26 at 11:38 A.M. revealed Registered Nurse (RN) #44 checking placement of Resident #44's PEG tube. RN #44 connected the PEG tube to a syringe and pulled back approximately 30 milliliters (ml) of gastric content. RN #44 then disconnected the syringe from the PEG tube and disposed of the gastric content into the toilet. Interview on 05/12/26 at 11:40 A.M. with RN #44 confirmed Resident #44's gastric content was disposed in the toilet, and RN #44 was aware it should have been placed back into Resident #44's stomach. Review of the policy for feeding tubes, dated 07/25, revealed prior to flushing the feeding tube, the nurse verifies proper placement by noting the length of the tubing or performing a measure of the pH of gastric secretions.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/18/2026
NAME OF PROVIDER OR SUPPLIER Good Shepherd Home		STREET ADDRESS, CITY, STATE, ZIP CODE 725 Columbus Ave Fostoria, OH 44830	
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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, pest control staff interview, and facility policy review, the facility failed to ensure the facility was free from bed bugs and affected areas were properly treated. This affected one (#89) of one residents reviewed for pests. The facility census was 80. Findings include: Record review for Resident #89 revealed the resident was admitted to the facility on [DATE] with diagnoses including pressure ulcer of the sacral region, history of malignant neoplasm of the rectum, vascular dementia, and congestive heart failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderately impaired cognition, required supervision with toileting and dressing, and moderate assistance with bathing. Observation on 05/11/26 at 9:45 A.M. revealed Resident #89 was not residing in room [ROOM NUMBER]. A blanket was laid in front of the door with a laundry cart in front of the door. Interview on 05/11/26 at 9:47 A.M. with Licensed Practical Nurse (LPN) #244 revealed Resident #89 was moved to room [ROOM NUMBER]. Observation on 05/12/26 at 1:22 P.M. of room [ROOM NUMBER] with Plant Operations (PO) Staff #241 revealed bed lines were on the bed; clothing was in the closet and drawers; a specialty wheelchair, cloth recliner, two tables, food and cups were on a table by the chair, and two fans. Interview 05/12/26 at 11:10 A.M. with Plant Operations (PO) Staff #241 revealed bed bugs were found on Resident #89 on 05/10/26. PO Staff #241 contacted Housekeeper #116, who came into the facility and placed two fans in room [ROOM NUMBER], and placed a blanket in front of the door and a laundry cart so no one would enter. Interview on 05/12/26 at 12:04 P.M. with Housekeeper #116 recalled receiving a call on 05/10/26 and came into the facility to set up fans and in room [ROOM NUMBER]. Housekeeper #116 stated no training was given and a call was made on 05/11/26 to a pest control company with bed bug treatment scheduled for 05/15/26. Interview on 05/12/26 at 1:22 P.M. with PO Staff #241 verified all of Resident #1's clothing and personal items were in the room (#118), lines were on the bed, and a cloth recliner, wheelchair, and two tables were also in the room. PO Staff #241 stated he would contact the pest control company to try to schedule a sooner visit. Observation of room [ROOM NUMBER] on 05/13/26 at 8:23 A.M. with the Director of Nursing (DON) revealed five adolescent bed bugs and multiple eggs were present on the cloth recliner. Interview on 05/13/26 at 10:15 A.M. with Pest Control Company Staff (PCCS) #1 confirmed an active bed bug infestation in room [ROOM NUMBER]. PCCS #1 confirmed bed bugs were located in screw wholes of the tables and dresser and found throughout the room with new and old feces found along with eggs. PCCS #1 stated he was in the facility on 05/10/26 for a routine spray and spoke with Housekeeper #116 to get diapers, clothes, and all personal items out of Resident #1's room before heat treating. He stated the drawers and closets needed to be open as well. PCCS #1 stated that due to everything still being left in the room, he could only spray around the perimeter of the room and another appointment would be needed once the facility cleaned out the room. Review of the undated policy titled, Bedbugs/Pest Control/Infestation Policy, revealed a pest management professional should inspect the suspect room, adjacent rooms, resident(s) new room, all furniture and equipment, and lounge and public area the family may have been using. The facility should frequently vacuum the premises, wipe down mattresses, launder bedding and clothing in hot water, and clean and sanitiz the dwelling.		