STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366236	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Village	422 North Burnett Road Springfield, OH 45503

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, resident and staff interviews, and medical record review, the facility failed to honor a resident's preferences for bathing. This affected one (Resident #77) of three residents reviewed for preferences. The facility census was 59.Findings include:Review of Resident #77's medical record revealed the resident had an admission date of 6/03/26. Diagnoses include acute and chronic respiratory failure, chronic diastolic failure, cerebral infarction, and weakness. The Minimum Data Set (MDS) assessment last revised on 6/10/26 revealed Resident #77 did not have any memory issues and required substantial/maximal assistance from staff with bathing and showering.Review of Resident #77's preferences dated 6/03/26 revealed the resident preferred to have showers.Review of the care plan last revised 06/04/26 revealed Resident #77 was at risk for decline in actives of daily living (ADL) related to a fall at home. Interventions include allow time for rest breaks and encourage the resident to participate in ADLs.Review of the shower log revealed Resident #77 received a bed bath on 06/11/26, 06/15/26, and 06/18/26 Interview on 06/23/26 at 7:54 A.M. with Resident #77 revealed the resident was receiving bed baths and preferred to have showers. Resident #77 stated he was not aware if the facility would be able to assist him with showers due to his recent stroke.Interview on 06/25/26 at 12:53 P.M. with the Regional Director of Nursing (RDON) #211 confirmed Resident #77 had received bed baths and not their preferred showers on 06/11/26, 06/15/26, and 06/18/26. RDON #211 confirmed Resident #77's preferences will be honored and the resident was given a shower on 06/25/26.This deficiency represents non-compliance investigated under Complaint Numbers 3011478 and 2661156.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, and policy review, the facility failed to ensure quarterly care conferences were offered/completed for Resident #34 and failed to ensure Resident #12's care plan was updated timely. This affected one (Resident #34) of three residents reviewed for care plan conferences and one (Resident #12) of 24 residents reviewed for care plan revisions. The facility census was 59.Findings include: 1. Review of the medical record for Resident #34 revealed an admission date of 05/08/23. Diagnoses included anxiety, insomnia, diabetes mellitus, chronic pulmonary disease, and heart failure. Review of the care conference documentation revealed care conferences were held on 06/30/25, 11/30/25, 01/22/26 and 04/22/26. The record review found no evidence of care conference being held for five months until 11/30/25. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 had intact cognition and was independent with most activities of daily living and mobility. Interview on 06/22/26 at 12:35 P.M. with Resident #34 reported facility had not held care conference on a quarterly basis. Interview on 06/23/26 at 1:38 P.M. with Regional Director of Clinical Services #211 stated the facility was cited for care conferences on the last annual and they completed an audit and training to ensure compliance. Interview on 06/23/26 at 4:40 P.M. with Social Service Director #194 and Regional Director of Clinical Services #211 confirmed the facility was missing a care conference for Resident #34 from 07/2025 to 10/2025. Review of facility policy titled IDT (Interdisciplinary) Team Members Participation in Resident Care Conferences dated 03/2023 revealed the IDT team shall ensure each resident had consistent and routine care conferences. 2. Review of the medical record for Resident #12 revealed an admission date of 03/26/26. Diagnoses included late onset Alzheimer's disease, schizoaffective disorder, anxiety, and major depressive disorder. Review of the progress note dated 05/08/26 revealed Resident #12 was referred to psychiatric services on 05/08/26. Resident #12 was first seen by psychiatric services on 05/19/26. Review of Resident #12's care plan revealed no goals or interventions were in the care plan regarding symptom monitoring, management, or interventions for anxiety, depression, and schizophrenia. There were no interviews for side effect monitoring for antianxiety, antidepressant, and antipsychotic medications. The nursing progress notes revealed on 06/11/26 at 11:48 A.M., poison control was called because Resident #12 had ingested a foreign material. At 1:04 P.M., Resident #12 informed housekeeping staff (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she wanted to die, planned to drink chemicals to make her die, and she had ingested body wash. Resident #12's physician and psychiatric nurse practitioner were called, and Resident #12 was pink-slipped (emergency involuntary psychiatric 72-hour hold) and taken to the emergency for further evaluation and treatment. Resident #12's care plan was last revised on 04/17/26 and did not include Resident #12's suicidal ideation. Interview on 06/25/26 at 11:57 A.M. with Social Services Designee (SSD) #194 confirmed Resident #12's care plan was not updated following suicidal ideation and involuntary psychiatric hold. Interview on 06/25/26 at 3:30 P.M. with Regional Director of Clinical Services (RDCS) #211 confirmed Resident #12's care plan should have been updated following suicidal ideation and involuntary psychiatric hold. This deficiency represents non-compliance investigated under Complaint Numbers 2661156 and 2965086.

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	366236	A. Building B. Wing	06/30/2026

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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 record review, staff interview, hospice interview, the failed to provide joint collaborative effort and ongoing hospice communication when Resident #61 exhibited a change in condition. This affected one (Resident #61) of two residents reviewed for death. The facility census was 59. Findings include: Review of the medical record for Resident #61 revealed an admission date of [DATE] and a discharge date of [DATE]. Diagnoses included cerebral atherosclerosis The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61 had moderate cognitive impairment. Review of the physician orders revealed Resident #61 was admitted to Hospice with a hospice diagnosis of cerebral atherosclerosis. Review of the nursing documentation dated [DATE] at 5:00 A.M. revealed Resident #61's treatment was completed as physician ordered. Resident #61 continued with a rattle to chest, and denies pain or discomfort. There was no documentation that hospice, the physician, or the resident's representative were notified of the newly documented rattling in the chest. The nursing documentation dated [DATE] at 6:00 A.M. revealed the nurse entered the room and found Resident #61 without signs of life. Hospice was then contacted after the resident was found deceased .Review of the hospice documentation revealed Resident #61 was pronounced deceased at 6:00 A.M. on [DATE].Interview with Hospice Registered Nurse (RN) #350 on [DATE] at 11:03 A.M. revealed hospice visited with Resident #61 on [DATE] and did not visit him until hospice was notified he was deceased . RN #350 stated hospice would expect a call from the facility for any significant change in condition, including new rattling in the chest, because hospice could have evaluated the resident and potentially initiated medications to help manage the rattling.Interview with the Director of Nursing (DON) on [DATE] at 10:24 A.M. revealed when a resident develops rattling in the chest, staff should increase monitoring to at least hourly checks and notify the physician, hospice, and the Power of Attorney. The DON confirmed the medical record did not show those notifications occurred and did not show increased monitoring or additional vital sign checks after the rattling was documented.Interview with Medical Director (MD) #400 on [DATE] at 11:33 A.M. revealed he was not informed of the rattling in the chest and stated he would expect to be notified if the rattling was persistent or represented a change in condition.This deficiency represents non-compliance investigated under Complaint Numbers 3022603 and 2965086.

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	366236	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, policy review, and review of manufacturer instructions, the facility failed to ensure adequate supervision and assistance were provided to the residents to prevent falls and failed to complete thorough investigations into the resident's falls. This affected two (Residents #54 and #61) of four residents reviewed for accidents. The facility census was 59.Findings include:1. Review of Resident #61's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included type two diabetes mellitus, general anxiety disorder, and muscle weakness.Review of the physician orders dated 09/19/24 revealed Resident #61 was admitted to hospice with a primary diagnosis of cerebral atherosclerosis. Resident #61 was in the terminal stage of illness and required intensive monitoring and care coordination.Review of the care plan dated 09/24/24 and last revised on 05/12/26 revealed Resident #61 was a low risk for falls related to gait/balance problems with an actual fall on 05/05/26 during care. Interventions included following facility fall protocol. Resident #61 required staff intervention to complete self-care and mobility activities and the resident was at risk for decline in functional ability and usual performance associated with complications. Resident #61's care plan did not have any safety interventions related to care with use of an air mattress.The Fall Risk Evaluation dated 01/24/26 identified Resident #61 was at a high risk for falls.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #61 had severe cognitive deficits. Resident #61 was totally dependent on staff for transfers and bathing and was dependent on staff with all other activities of daily living (ADL) including rolling left and right, sitting to lying, and lying to sitting transfers. The progress note dated 05/05/26 at 6:00 P.M. revealed Resident #61 experienced a fall during wound care that shift. While Licensed Practical Nurse (LPN) #141 was obtaining supplies from the bedside table, Resident #61 reached and shifted position, resulting in rolling off the bed. LPN #141 attempted to intervene and prevent the fall but was unsuccessful. Resident #61 contacted the floor and struck her head. A small open area noted to the head with active bleeding measuring one centimeter (cm) in length with no width measurement. Bleeding was controlled with pressure and the site was cleansed. Emergency Medical Services (EMS) was called at this time.Review of the hospital records dated 05/05/26 and 05/06/26 revealed Resident #61 presented with a fall and head injury. Resident #61 rolled out of bed, hitting her head, and sustaining an abrasion to the forehead. Resident #61 sustained a left frontal contusion and abrasion. Resident #61 was alert and oriented at baseline mental status. Review of the medical record revealed there was no fall investigation for Resident #61's fall on 05/05/26. The facility did not provide any investigation into Resident #61's fall on 05/05/26.During an interview on 06/24/26 at 9:14 A.M., LPN #141 revealed she was performing wound care on Resident #61 on 05/05/26. LPN #141 stated she was rolling Resident #61 during wound care. The air mattress was in use, but the mattress was not placed in static mode prior to the care activity. LPN #141 documented the air mattress almost threw the resident during the rolling motion and the air pushing the resident off the bed. Resident #61 struck her forehead. LPN #141 confirmed when Resident #61 fell, the resident was positioned on her stomach, and the resident was too heavy to roll back over independently. LPN #141 stated Resident #61 was a two-person assist whenever she was in the room and confirmed she was actively handling Resident #61 during the rolling for wound care. During an interview on 06/25/26 at 11:33 A.M., Registered Nurse (RN) #350 confirmed the air mattress provided by hospice had a firm or static mode setting or a maximum inflate button to make the mattress firmer for repositioning, wound care, or incontinence care. RN #350 also confirmed proper safety measures during resident transfers included ensuring the resident was positioned in the middle of the bed prior to care and utilizing two staff members to ensure safety during all transfers.During an interview on 06/25/26 at 1:56 P.M., the Director of Nursing (DON) and Regional Clinical Nurse #211 confirmed the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility did not complete a fall investigation and obtain witness statements and determine the root cause of Resident #61's fall on 05/05/26. The DON stated the fall investigation would be in the resident's electronic medical record. Regional Clinical Nurse #211 stated the facility was actively addressing fall management through its Quality Assurance and Performance Improvement (QAPI) program.Review of the Advacare Guidelines for air mattress systems revealed the mattress has a static mode setting that provided a firm surface to make it easier for the patient to transfer or reposition. The static button should be pressed to set the mattress in static mode.2. Review of the medical record for Resident #54 revealed a re-admission date of 11/06/24. Diagnoses included fracture of the upper end of the right humerus with routine healing, chronic obstructive pulmonary disease, generalized anxiety disorder, and mood disorder.Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/18/25, revealed Resident #54 was cognitively intact. Resident #54 was independent with activities of daily living including bed mobility, transfers, ambulation, dressing, toileting, and personal hygiene. Resident #54 had no falls.Review of the nursing documentation dated 02/13/26 revealed Resident #54 experienced a witnessed fall while walking outside the facility toward the transport bus for a scheduled appointment. Resident #54 stated, I fell over my foot. The physician was notified, Emergency Medical Services (EMS) was contacted, and the resident was transported to the hospital. Nursing documented the resident would receive a therapy evaluation for ambulation and gait upon return to the facility. A subsequent nursing note documented the fall was witnessed and the resident did not strike his head.Review of the medical record revealed there was no fall investigation for Resident #54's fall on 02/13/26. The facility did not provide any investigation including any staff statements into Resident #54's fall on 05/05/26. There was no root cause of Resident #54's fall.Review of the hospital records dated 02/13/26 through 02/15/26 revealed Resident #54 was evaluated following the fall and reported pain and rated the pain eight out of ten (from a pain scale ranging from zero (no pain) to ten (most severe pain)). Diagnostic imaging identified an acute comminuted fracture involving the surgical neck of the proximal right humerus with anterior displacement of the diaphysis in relation to the humeral head. A sling was applied, pain management was initiated, and no surgical intervention was recommended. Review of the post fall documentation dated 02/15/26 revealed Resident #54 experienced another unwitnessed fall after returning to the facility against medical advice from the hospital. Resident #54 was found sitting beside the bed and stated, I fell down. The post fall investigation identified the reason for the fall as Resident #54 just left the hospital without being discharged , returned to facility on 7:00 A.M. to 7:00 P.M. shift The investigation did not identify an actual cause of the fall or evaluate factors contributing to the event. The only intervention implemented was education, instructing Resident #54 to use call light when assistance was needed.The facility was unable to provide an investigation including any witness statements regarding Resident #54's fall on 02/15/26.Review of the physician orders dated 02/16/26 revealed orders for the resident to remain non-weight bearing to the right arm, perform circulation checks to the radial and brachial pulses every shift, and report abnormalities following the right humerus fracture.The nursing documentation dated 02/16/26 revealed hospital staff informed the facility Resident #54 had left the hospital against medical advice due to smoking in his hospital room. Nursing documented Resident #54 had a right humerus fracture with anterior displacement, required no surgical intervention, was to remain in a sling, remain non-weight bearing, and follow up with Orthopedics.Review of the plan of care, revised 02/17/26, revealed Resident #54 was at risk for falls related to gait and balance problems and a previous fall with fracture. Interventions included ensuring the call light remained within reach, educating the resident to request assistance when needed, ensuring appropriate footwear when ambulating, following the facility fall protocol, maintaining non-weight bearing status to the right arm with a sling as tolerated, therapy evaluation and treatment, educating the resident to pick up his feet while ambulating, and positioning the right side of the bed against the wall to enhance floor space. Review of the post fall documentation dated 05/24/26 revealed Resident #54 experienced an unwitnessed fall at approximately 2:00 A.M. while (continued on next page)

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	366236	A. Building B. Wing	06/30/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sleeping. Resident #54 rolled from the bed after continuing to sleep near the edge of the bed despite being instructed several times not to do this because he was at a high risk for falls. Resident #54 sustained a skin tear to the left elbow. The documentation revealed the bed height was appropriate, and the resident was using his prescribed assistive device. The corresponding nursing note documented the resident was found lying on his back with a skin tear to the left elbow, denied striking his head, and was assisted back to bed.Interview with the Director of Nursing (DON) on 06/25/26 at 10:32 A.M. revealed the reason documented for the 02/15/26 fall investigation was not a valid explanation for the fall. The Director of Nursing stated all three falls required further review.Interview with the DON and Regional Clinical Nurse #211 on 06/25/26 at 1:56 P.M. revealed the post fall assessments should have been completed in their entirety. They confirmed the fall investigations were incomplete, and the interventions implemented following the falls were not appropriate. Regional Clinical Nurse #211 stated the facility was actively addressing fall management through its Quality Assurance and Performance Improvement (QAPI) program.Review of the facilities policy titled Accidents and Supervision, dated in 2025, revealed the facility is required to provide adequate supervision and assistive devices based on individual resident assessed needs and ensure staff are trained and monitored to consistently implement interventions. There are systematic approaches the facility should take: identification of hazards and risks, evaluation and analysis the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents, implementation of interventions, monitoring and modification for care plans, and supervision to prevent further falls. This deficiency represents non-compliance investigated under Complaint Number 3022603.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366236	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure a resident who had a history of septic shock and urinary tract infection (UTI) received physician ordered antibiotics to treat the UTI and seen by infectious disease as recommended on the hospital discharge orders. This affected one (Resident #67) of five residents reviewed for UTIs. The facility census was 59.Findings include:Review of Resident #67's medical record revealed an admission date of 06/06/25. Diagnoses included Alzheimer's disease, obstructive and reflux uropathy, sepsis, and benign prostatic hyperplasia. The significant change Minimum Data Set 3.0 (MDS) assessment completed 08/22/25 revealed Resident #67 had short- and long-term memory impairment, was not oriented to person, place, or time, and was dependent on staff assistance for all personal care.Review of the nursing progress notes revealed Resident #67 was hospitalized from [DATE] to 06/06/25 for septic shock secondary to catheter-associated urinary tract infection (CAUTI) and gastrointestinal bleed (GIB). Review of the discharge orders revealed they included to follow up with urology in one week for stent removal. Continue intravenous (IV) Ampicillin (antibiotic) two grams every four hours for UTI. Continue IV Ceftriaxone (antibiotic) two grams every 12 hours for five weeks for UTI, ending on 07/03/25; Follow up with infectious disease clinic one week after discharge.Review of the physician orders and medication administration record (MAR) for June 2026 revealed the order for IV Ceftriaxone (antibiotic) two grams every 12 hours for five weeks for UTI, ending on 07/03/25 was not administered according to physician orders on 06/06/25, 06/07/25, 06/08/25, and 06/09/25. On 06/06/25, 06/07/25, 06/08/25, and 06/09/25, Resident #67 received one grams (not two grams as ordered) intramuscularly (IM) twice daily (five doses). On 06/16/25, IV Ceftriaxone (antibiotic) two grams every 12 hours was stopped (despite orders to continue through 07/03/25.Review of a nursing progress note dated 06/09/25 (late entry, note created 06/22/25) stated a telephone call was placed to the infectious disease clinic and the clinic stated they will call back with the date and time of an appointment.The nursing progress note dated 06/19/25 revealed Resident #67's peripherally inserted central catheter (PICC) line was removed due to Resident #67 completed IV antibiotic therapy.The nursing progress note dated 06/19/25 (late entry, note created 06/22/26) stated the infectious disease clinic called back and scheduled Resident #67's follow up appointment for 06/25/25.The nursing progress note dated 06/20/25 revealed Resident #67 continued to show signs of a UTI. Resident #67's physician was contacted and received new orders to start Amoxicillin oral antibiotic 500 milligrams (mg) three times per day for seven days, with treatment ending on 06/27/25. On 06/21/25, the physician order changed from Amoxicillin oral antibiotic 500 mg three times per day to Ampicillin oral antibiotic 500 mg three times per day to match the previous antibiotic type. The progress notes revealed Resident #67 continued to show signs and symptoms of UTI and the antibiotic order was extended an additional seven days to be completed on 07/03/25.There was no indication Resident #67 went to Infectious Disease Clinic on 06/25/26 or at any time during Resident #67's stay at the facilty.Interview on 06/29/26 at 10:40 A.M. with Infectious Disease Clinic #700 confirmed Resident #67 was seen by the physician on 06/05/25 while he was in the hospital. The clinic confirmed Resident #67 was not seen for further appointments.Interview on 06/29/26 at 3;43 P.M. with Regional Director of Clinical Services (RDCS) #211 confirmed Resident #67's IV and IM antibiotic treatments for UTI and sepsis ended earlier than originally ordered by the infectious disease clinic. RDCS #211 confirmed Resident #67 did not receive the IV Ceftriaxone (antibiotic) two grams every 12 hours 06/06/25, 06/07/25, 06/08/25, and 06/09/25. RDCS #211 confirmed Resident #67 continued to show signs and symptoms of a UTI after completing IV and IM antibiotic treatments and was started on oral antibiotics. RDCS #211 confirmed Resident #67 had an appointment scheduled with the infectious disease clinic that he did not attend.This deficiency represents non-compliance investigated under Complaint Numbers 2576086, 2661156, and 2965086.

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	366236	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, medical record review, and policy review, the facility failed to ensure the resident's oxygen was being administered according to physician orders. This affected three (Residents #34, #47, and #75) of four residents reviewed for oxygen. The facility census was 59.Findings include:1. Review of the medical record for Resident #34 revealed an admission date of 05/08/23. Diagnoses included chronic pulmonary disease and heart failure. Review of the physician orders dated 08/15/25 revealed oxygen should be set to four liters via nasal cannula. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #34 intact cognition and was independent with most activities of daily living and mobility. Review of the plan of care dated 06/08/26 revealed Resident #34 was on oxygen therapy with interventions for oxygen settings of four liters delivered by nasal cannula. Observation and interview on 6/22/26 at 12:35 P.M. with Resident #34 revealed she thought she was supposed to be on about five liters of oxygen. The concentrator tank was observed to be set at 2.5 liters. Interview and observation on 06/22/26 at 1:02 P.M. with Licensed Practical Nurse (LPN) #215 confirmed the oxygen was set to 2.5 liters and verified the physician order stated it should be set to four liters. LPN #215 adjusted the oxygen level to four liters. 2. Review of the medical record for Resident #47 revealed an admission date of 04/30/26. Diagnoses included chronic obstructive pulmonary disease. The Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 had intact cognition. Review of the Clinical admission assessment dated [DATE] revealed Resident #47 utilized continuous oxygen at two liters per minute via nasal cannula for a chronic respiratory condition. Review of physician orders revealed an active order dated 05/01/26 for oxygen at two liters per minute continuously via nasal cannula every shift. Observation on 06/22/26 at 3:09 P.M. revealed Resident #47 was receiving oxygen via nasal cannula. The oxygen concentrator was observed to be set at three liters per minute. Review of the physician order at the time of the observation confirmed the resident was ordered to receive two liters per minute. Interview with Licensed Practical Nurse (LPN) #141 on 06/22/26 at 3:09 P.M. confirmed the physician's order directed oxygen to be administered at two liters per minute and confirmed the oxygen concentrator was set at three liters per minute at the time of the observation. 3. Medical record review for Resident #75 revealed an admission date of 06/19/26. Diagnoses included acute on chronic diastolic heart failure, chronic obstructive pulmonary disease, and acute and chronic respiratory failure (COPD). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366236	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Village	422 North Burnett Road Springfield, OH 45503

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician order dated 06/19/26 revealed Resident #75 had an order for oxygen at two liters per minute. Review of the care plan last revised 06/23/26 revealed Resident #75 has altered respirator saturations and difficulty breathing related to COPD. Interventions included to administer oxygen as ordered. Observation on 06/22/26 at 2:29 P.M. revealed Resident #75 was receiving oxygen at 3.5 liters per minute. Interview on 06/22/26 at 2:54 P.M. with the Director of Nursing (DON) confirmed Resident #75 was receiving 3.5 liters per minute and his physician orders were to be administered at two liters per minute. Review of the facility policy titled Oxygen Administration Level III, revised October 2010, revealed staff were to verify physician orders before administering oxygen, review the resident's care plan, ensure the proper flow of oxygen was being administered, adjust the oxygen delivery device to the prescribed flow rate, observe the resident while receiving oxygen therapy, and document the oxygen flow rate, route, rationale, and resident response following oxygen setup or adjustment.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to maintain accurate documentation on the disposition of controlled substances. This affected one (Resident #20) of one resident reviewed for pain management. This had the potential to affect 31 residents at the facility who utilize controlled substances. The facility census was 59.Findings include:Review of Resident #20's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included chronic pain. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 had intact cognition and pain in thoracic spine.Review of Medication Monitoring/Control Records for Resident #20 revealed one Hydrocodone five milligrams (mg)/Acetaminophen (Scheduled II controlled substance) 325 mg tablet was removed from locked storage for Resident #20's administration six times on [DATE] at 6:00 P.M., [DATE] at 5:10 P.M., [DATE] at 10:34 A.M., [DATE] at 5:03 P.M., [DATE] at 1:48 P.M., and [DATE] at 9:30 A.M. Review of Resident #20's Medication Administration Record (MAR) revealed Hydrocodone five mg/Acetaminophen 325 mg was not documented as administered on [DATE] at 6:00 P.M., [DATE] at 5:10 P.M., [DATE] at 10:34 A.M., [DATE] at 5:03 P.M., [DATE] at 1:48 P.M., and [DATE] at 9:30 A.M. Review of the Medication Monitoring/Control Records for Resident #20 revealed eight tablets of Hydrocodone five mg/Acetaminophen 325 mg were recorded as waste (expired) on [DATE] and indicated these doses were transferred to other Disposal Record. Review of the facility's Record of Disposal lists six tablets of Hydrocodone five mg/Acetaminophen 325 mg for Resident #20 as destroyed by drug disposal bottle on [DATE].Interview on [DATE] at 4:10 P.M. with Assistant Director of Nursing (ADON) #148 confirmed there was no documentation in Resident #20's MAR that Hydrocodone five mg/Acetaminophen 325 mg was administered on [DATE] at 6:00 P.M., [DATE] at 5:10 P.M., [DATE] at 10:34 A.M., [DATE] at 5:03 P.M., [DATE] at 1:48 P.M., and [DATE] at 9:30 A.M. ADON #148 confirmed the discrepancy of number of tablets of Hydrocodone five mg/Acetaminophen 325 mg documented as wasted on the facility's Medication Monitoring/Control Records (eight tablets) and the facility's Record of Disposal (six tablets).Review of the facility policy titled Controlled Substances revised [DATE] revealed the facility (will comply) with all laws, regulations, and other requirements related to handling, storage, disposal and documentation of controlled substances.The facility policy titled Administering Medications revised [DATE] revealed the individual administering the medication initials the resident's MAR after administering each medication.This deficiency represents non-compliance investigated under Control Number 2748117.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and policy review, the facility failed to have a complete policy to address when it was the facilities responsibility to replace lost or missing dentures. This affected one (Resident #36) of three residents reviewed for dental services. The facility census was 59.Findings include:Review of Resident #36's medical record revealed an admission date of 06/07/24. Diagnoses included paraplegia, psychoactive substance abuse, major depressive disorder, and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 had intact cognition. Review of the care plan dated 03/05/25 revealed Resident #36 had oral and dental health problems to rule out injury, poor nutrition, and poor oral hygiene. The care plan did not address that Resident #36 had dentures and did not have interventions for cleaning the dentures and safe place for storage of the dentures.Interview on 06/24/26 at 11:47 A.M. with Resident #36 revealed on or around the evening of 05/23/26, staff removed their upper dentures and placed them on their bedside table before falling asleep. While Resident #36 was resting, an unknown staff member entered their room and cleaned their room and when they awoke, they discovered their upper dentures were missing. Resident #36 notified the Administrator of the missing upper dentures and after an extensive search, the facility was unable to locate the missing upper dentures. The facility reached out to the dental office and a replacement was quoted at approximately $1,400. Resident #36 confirmed they did not have their upper dentures due to a dispute with the facility regarding who would be responsible for the cost of the dentures.Interviews on 06/24/26 at 4:11 P.M. with the Administrator confirmed Resident #36 had reported their upper dentures missing to the facility and staff had searched the resident's room and were unable to locate the upper dentures. Afterwards, the facility reached out to the dental office and the missing upper dentures were quoted at $1,500 dollars. After investigating, the facility had concluded that neither the resident nor the facility could be found at fault and had told the resident to pay half of the cost of the dentures. On 06/29/26 at 3:13 P.M. confirmed the Administrator confirmed the facility's policy titled Dental Services did not specify the facility's protocol for lost or broken dentures when it is the facilities responsibility.Review of the undated facility policy titled Dental Services revealed the facility will identify those instances when the loss or damage of partial or full dentures is the facilities responsibility, such as when a staff member discards dentures on a meal tray. Under D of the policy, it stated to Insert facility specific protocol for lost or broken dentures here. However, the facility had not inserted their specific protocol for lost or broken dentures.This deficiency represents non-compliance investigated under Complaint Number 3022265.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations and resident and staff interviews, the facility failed to ensure meals were palatable and served at proper temperature. This had the potential to affect all 59 residents who receive their meals from the kitchen. Findings include:Interview on 06/22/26 at 3:47 P.M. with Resident #7 reported the food was terrible and most of the time it was cold, had no taste, and meats were tough.Review of the dinner menu for 06/24/26 revealed dinner was a chicken ranch wrap, side salad, vegetable soup, and a slice of yellow cake for dessert.Observations of holding temperatures at the start of dinner service on 06/24/26 at 5:07 P.M. revealed the chicken strips in the chicken ranch wrap were 170 degrees Fahrenheit (F) and the vegetable soup was 178 degrees F.Observation of the test tray at the end of dinner service and interview with Dietary Manager (DM) #158 on 06/24/26 at 6:20 P.M. revealed the chicken strips in the chicken ranch wrap were 83 degrees F and falling. The wrap was bland, cold and soggy. DM #158 confirmed the temperature of the chicken strips was outside of safe holding temperatures.This deficiency represents non-compliance investigated under Complaint Number 2576086.