

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395018	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Good Shepherd Home Raker Center		STREET ADDRESS, CITY, STATE, ZIP CODE 601 St John Street Allentown, PA 18103	
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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on review of facility policy, clinical records, facility documentation, and staff interview, it was determined the facility failed to ensure each resident was free from physical abuse which resulted in physical injuries of abrasions and ecchymosis for one of six sampled residents. (Resident 1) Findings include: Review of the facility policy entitled, Identification and Reporting of Suspected Adult and Older Adult Abuse, last reviewed September 2025, revealed the purpose of the policy was to protect the health, welfare, and well-being of residents. The policy applied to all staff of the Good [NAME] Rehabilitation Network. Abuse was defined as the occurrence of the infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. A caretaker was defined as an individual that had assumed responsibility for the provision of care. Patients had the right to be free from all forms of abuse. Clinical record review revealed Resident 1 had diagnoses that included Hemiplegia (complete or severe paralysis of one entire side of the body), following a stroke affecting the left dominant side, functional Quadriplegia (paralysis affecting all four limbs and the torso), Ataxia (neurological term used to describe a lack of voluntary muscle coordination resulting in unsteady movements), Aphasia (neurological communication disorder that impairs your ability to speak and write), Chronic Respiratory Failure, Depression (serious mental health condition, most commonly causing ongoing sadness, low energy, and a loss of interest in life), gastrostomy status (surgical opening through the stomach used to deliver nutrition, fluids and medication directly), and tracheostomy status (surgically created opening in the windpipe through the front of the neck). Review of Resident 1's Minimum Data Set (periodic assessment of the resident's current status), dated April 29, 2026, revealed Resident 1 was alert and oriented and was dependent on staff for all activities of daily living. Review of Resident 1's care plan identified Resident 1 had limited physical mobility related to history of stroke with impairment in flexibility, strength, and motor control. Resident 1 was dependent on staff for dressing, personal hygiene, and incontinence care. There was an intervention for staff to provide assistance for all functional tasks in and out of bed. Further review of the care plan also identified that the resident had bowel incontinence. There was an intervention for him to wear incontinence products. Review of facility documentation dated July 11, 2026, revealed Resident 1 was non-verbal but used a letter board to facilitate communication. Resident 1 was identified as being able understand speech and being understood with the use of the letter board. Resident 1 was noted as a reliable historian with no history of confabulation or confusion per the medical record and staff interview. Further review of facility documentation revealed on July 11, 2026, at 7:30 a.m., a nurse aide (NA 1) went into Resident 1's room to provide care. NA 1 observed dried blood on his face over the left eyebrow and immediately reported the observation to Registered Nurse (RN) 2. RN 2 did a skin assessment and observed other areas on the resident's neck and chest. RN 2 noted that there was an abrasion (superficial injury where the topmost layer of skin, the (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	epidermis, was rubbed or scraped off) on his left temple and scratches/red marks on his chest. Staff began to question Resident 1 to which he reported to staff of a nurse (RN 1) coming into the room to complete care at 3:00 a.m. on July 11, 2026. Review of the facility investigation report revealed Resident 1 told RN 1 she was hurting him and he tried to push her away. Resident 1 then stated to a staff member that RN 1 pinched him and hit him on the left side of his face and neck. Further review of facility documentation dated July 11, 2026, revealed the Nursing Home Administrator interviewed Resident 1. Resident 1 confirmed the incident of RN 1 coming into the room at 3:00 a.m. to provide incontinence care but it had hurt and he pushed her away. Resident 1 stated, RN 1 hit him and pinched him on the left side of his face and neck. He further indicated RN 1 held him down with her weight and her arms. Review of investigative statements revealed Resident 1 reported the sequence of events to numerous staff during interviews which led the facility to determine, Resident 1's sequence of events to be credible. Review of investigative statements dated July 11, 2026, revealed the following: On July 11, 2026, at 12:00 p.m., RN 3 a 7:00 p.m., to 7 :00 a.m., nurse indicated Resident 1 used the communication board to tell her that RN 1 was providing incontinence care and it hurt. Resident 1 stated he tried to defend himself but RN 1 went crazy and she pinched and punched me. On July 11, 2026, at 1:00 p.m., Licensed Practical Nurse (LPN) 1, a nurse assigned to 11 :00 a.m. to 7:00 p.m. shift, revealed Resident 1 stated multiple times it was RN 1 who caused the injuries and it happened at 3:00 a.m. LPN 1 noted Resident 1 had clotted blood on the left side of his eyebrow, a scratched area on the left side of his neck, and superficial scratches on three different areas of his left upper chest. On July 11, 2026, at 1:30 p.m., RN 4, a nurse assigned to 7:00 a.m. to 7:00 p.m. shift, said that Resident 1 used his communication board to state that RN 1 was by herself when she pinched and punched him. Resident 1 also stated that RN 1 put her weight on him when he was awake at 3:00 a.m. Review of a nurse practitioner note dated July 13, 2026, revealed that the resident had acute abrasions noted to the area above the left eyebrow, left lateral neck, and left upper anterior chest, as well as a small area of ecchymosis (bruising) to the left clavicle (bone that connects your shoulder blade to your breastbone). At that time, Resident 1 reported that he had mild tenderness to the left cheekbone. Resident 1 again stated that RN 1 hit him on the head, pinched him, and put her body weight on the left side of his body. Interview conducted on July 21, 2026, at 1:40 p.m., with Resident 1 who used the communication board to indicate RN 1 abused him during the night and hurt him. In an interview on July 21, 2026, at 10:05 a.m., the Director of Nursing revealed the facility substantiated physical abuse, and RN 1's employment was terminated. Based on the above findings, the facility failed to ensure that Resident 1 was free from physical abuse which resulted in injury of abrasions and ecchymosis. 201.14(a) Responsibility of licensee 201.18(b)(1) Management 201.29(a) Resident rights 211.12(d)(1)(5) Nursing services		