STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395018	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Home Raker Center	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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43883 Based on clinical record review, observation, and resident interview, it was determined that the facility failed to ensure that a call bell was accessible for one of 20 sampled residents. (Resident 53) Findings include: Clinical record review revealed that Resident 53 had diagnoses that included multiple sclerosis (damage to the nerves), quadriplegia (paralysis that affects all limbs of the body), and depression. Review of the Minimum Data Set assessment dated [DATE], revealed that the resident had no cognitive impairment and was dependent on staff for activities of daily living. Review of the care plan revealed that staff was to ensure that the resident's call bell was within reach at all times. On August 20, 2024, at 1:07 p.m., Resident 53 was observed in her wheelchair in her room. The resident stated she wanted assistance to go back to bed. The call bell was placed on top of the resident's bed. The resident stated that the call bell was difficult to reach when it was on top of her bed. On August 21, 2024, at 12:51 p.m., the resident was observed in her room in her wheelchair. The call bell was not visible and the resident stated that she did not know where it was located. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 45244 Based on review of the Resident Assessment Instrument (RAI) User's Manual and clinical record review, it was determined that the facility failed to timely complete and transmit Minimum Data Set (MDS) assessments for three of 20 sampled residents. (Residents 32, 48, 67) Findings include: The Long Term Care Facility RAI User's Manual which provides instructions and guidelines for completing required MDS assessments, (mandated assessments of a residents' abilities and care needs), dated October 2019, indicated that annual, quarterly, and admission assessments were to be completed and transmitted electronically to the Centers for Medicare/Medicaid services (CMS) no later than 14 days after the Assessment Reference Date (ARD) which refers to the last day of the assessment observation period. Clinical record review revealed that Resident 32 had a quarterly MDS assessment, dated July 11, 2024, with an ARD of July 26, 2024, noted as still in progress and had not yet been completed or transmitted as per the time requirements. This quarterly assessment was overdue and had not been completed within the required time frame. Clinical record review revealed that Residents 48 and 67 had annual MDS assessments, dated July 15, 2024, with an ARD of July 24, 2024, noted as still in progress and had not yet been completed or transmitted as per the time requirements. These annual assessments were overdue and had not been completed within the required time frame.

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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 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. 43883 Based on clinical record review, resident interview, and staff interview, it was determined that the facility failed to ensure that physician's orders were implemented for two of 20 sampled residents. (Residents 50, 61) Findings include: Clinical record review revealed that Resident 50 had diagnoses that included myotonic muscular dystrophy (genetic disorder that causes progressive muscle loss), congestive heart failure, and respiratory failure. A physician's order dated July 22, 2024, directed staff to weigh the resident every week on Mondays due to congestive heart failure and weight loss. There was no evidence that staff attempted to weigh the resident on July 29, 2024, and August 5, 12, and 19, 2024. In an interview on August 22, 2024, at 12:38 a.m., the Director of Nursing confirmed that there was no evidence that staff weighed the resident per physician's order. Clinical record review revealed that Resident 61 had diagnoses that included multiple sclerosis (damage to the nerves), quadriplegia (paralysis that affects all limbs of the body), neuromuscular dysfunction of the bladder, and depression. The resident used a urinary catheter (a tube used to drain urine from the bladder). In an interview on August 20, 2024, at 12:30 p.m., the resident stated that she occasionally had pain to the catheter insertion site. She stated she was to see a urologist but has not yet had an appointment. A physician's order dated July 15, 2024, directed staff to consult urology for the resident's catheter tube site pain. There was no evidence that staff scheduled the urologist appointment. In an interview on August 22, 2024, at 11:26 a.m., the Director of Nursing confirmed that staff did not schedule the urologist appointment, per the physician's order. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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. 43883 Based on observation and review of facility documentation, it was determined that the facility failed to store and serve food under sanitary conditions in the kitchen. Findings include: Observation of the kitchen on August 20, 2024, at 10:15 a.m. revealed the following: There were two fruit flies in the food preparation area. There was a large fly on the cold preparation station. There was a pan of chicken on the same preparation station. The plastic wrap on the pan did not fully cover the pan and the chicken was open to air. There was an uncovered garbage can by the coffee preparation station. There was cheese in the reach in refrigerator with a use by date of August 18, 2024. There was a cup used to scoop thickener powder that was stored in the container, in direct contact with the thickener. Observation of the tray line service on August 21, 2024, at 11:10 a.m., revealed the following: Dietary Employee 1 (DE 1) was wearing gloves and operating the tray line. On multiple occasions, DE 1 turned away from the tray line and obtained food items from the refrigerator. DE 1 returned to the tray line and continued assembling resident meals, which included touching ready to eat foods without changing gloves or performing hand hygiene. There was a cooler that contained items for meal service, which included yogurt, a potentially hazardous food item. The door to the cooler was propped open during tray line service. Observation of the thermometer in the cooler at 11:40 a.m., revealed that the internal temperature was above proper refrigeration and cold holding temperature of 41 degrees Fahrenheit (F) and had reached 55 degrees F. There was a second cooler that contained juice and thickened beverages. The cooler was also kept open during meal service, there was no thermometer observed in the second cooler. Review of facility temperature logs revealed that food temperatures were to be monitored and recorded when the food items were cooked and while they were held for service. Review of temperature logs for August 2024, revealed the following: There was no evidence that staff monitored the holding temperatures for the breakfast meal on August 1 through 21, 2024. There was no evidence that staff monitored the holding temperatures for the lunch meal on August 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 14, 16, 17, 18, and 19, 2024. There was no evidence that staff monitored the holding temperatures for the dinner meal on August 3 and 4, 2024. 28 Pa. Code 201.18 (b)(3)(e)(2.1) Management.