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	09/23/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure that residents were free from potential chemical restraints for one of five sampled residents who were ordered psychotropic medications. (Resident 26) Findings include:Clinical record review revealed that Resident 26 had diagnoses that included mood disorder and dementia. Review of the Minimum Data Set assessment dated [DATE], revealed that the resident was cognitively impaired and had been administered an anti-anxiety medication. On June 16, 2025, a physician ordered staff to administer an anti-anxiety medication, (alprazolam), every eight hours as needed for anxiety and agitated behaviors. There was no date in the order that indicated when staff was to stop administering the as needed medication. Review of Resident 26's Medication Administration Record revealed that staff had administered the alprazolam 21 times in July 2025, 17 times in August 2025, and 17 times in September 2025. There was no documented evidence that the physician had re-evaluated continued use beyond 14 days of the as needed anti-anxiety medication. In an interview on September 23, 2025, at 8:50 a.m., the Administrator stated that there had been no date added to the order that indicated when staff were to stop administering the anti-anxiety medication. 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessments were completed to accurately reflect the residents' current status for three of 20 sampled residents. (Residents 1, 2, and 7) Findings include: Clinical record review revealed that Resident 1 had diagnoses that included cerebral atherosclerosis and coronary artery disease. A physician's order dated July 1, 2025, directed staff to administer an anti-platelet medication (clopidogrel bisulfate). Review of the MDS assessment dated [DATE], revealed that the resident was administered an anti-coagulant medication during the review period, not an anti-platelet medication. The MDS inaccurately reflected the use of an anti-coagulant medication. Clinical record review revealed that Resident 2 had diagnoses that included peripheral artery disease and depression. A physician's order dated October 9, 2023, directed staff to administer an anti-platelet medication (clopidogrel bisulfate). Review of the MDS assessments dated June 12, 2025, and August 28, 2025, revealed that the resident was administered an anti-coagulant medication during the review period, not an anti-platelet medication. The MDS assessments inaccurately reflected the use of an anti-coagulant medication. Clinical record review revealed that Resident 7 had diagnoses that included diabetes mellitus and adjustment disorder. A physician's order dated November 23, 2021, directed staff to administer an anti-depressant medication (sertraline). Review of the MDS assessment dated [DATE], revealed that the resident was not administered an antidepressant medication and that the resident had received a dose of insulin during the review period. Review of Resident 7's Medication Administration Record for August 2025 revealed that the resident did not receive any insulin and was administered an antidepressant medication in the during the review period. The MDS inaccurately reflected administration of insulin and non-use of an antidepressant medication. In an interview on September 23, 2025, at 9:42 a.m., the Registered Nurse Assessment Coordinator confirmed that Resident 1's, 2's, and 7's, MDS assessments were inaccurate and did not reflect the residents' current status.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan that addressed each resident's needs as identified in the comprehensive assessment for two of 20 sampled residents. (Residents 16 and 36)Findings include: Clinical record review revealed that Resident 16 was admitted to the facility on [DATE], and had diagnoses that included adjustment disorder. The Minimum Data Set (MDS) Care Area Assessment (CAA) summary dated March 20, 2025, noted that the resident's psychotropic drug use was to be addressed in the care plan. Review of the medication administration records for March through September 2025, revealed the resident received an antidepressant (sertraline), which was classified as a psychotropic drug, during the review period. There was no documented evidence that interventions to address Resident 16's psychotropic drug use were included in the current care plan. In an interview on September 22, 2025, at 3:20 p.m., Registered Nurse 1 (RN1) confirmed there was no documented evidence that the psychotropic drug use was addressed in the Resident's 16 current care plan. Clinical record review revealed that Resident 36 was admitted to the facility on [DATE], and had diagnoses that included spastic quadriplegia cerebral palsy and seizure disorder. Review of the MDS assessment dated [DATE], indicated that the resident received oxygen through her nose while she was a resident. A physician's order dated September 9, 2021, instructed staff to apply oxygen at two liters per minute through a nasal cannula every night. Review of the treatment administration record for September 2025 revealed that the resident received oxygen every night. There was no documented evidence that the use of oxygen was included in the resident's current care plan. In an interview on September 23, 2025, at 9:45 a.m., RN2 confirmed that there was no documented evidence that oxygen was addressed on Resident 36's current care plan. 28 Pa. Code 211.12(d)(1)(5) Nursing services.