STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515038	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Nursing Home	159 Edgington Lane Wheeling, WV 26003

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 - Immediate jeopardy to resident health or safety 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 record review and staff interviews the facility failed to provide an environment free from accident hazards by not assessing the need for hand rail assist bars. This failure created an immediate jeopardy situation and caused the entrapment of one resident who was found deceased with their head and arm between the hand rail and mattress. This failed practice had the potential to affect all residents residing in the long term care facility because all residents except one (1) have the bilateral hand rail assist bar. Resident identifier: #100. Facility census: 174. Findings Include:a) Resident #100A review of the Facility Reported Incident (FRI) completed on [DATE] at approximately 11:00 AM revealed the following:On [DATE] at 10:25 PM upon entering the resident's room, staff noticed the resident's lower body was on the floor but her head was between the hand held assist rail and mattress. Staff immediately placed her back into bed and assessed her. It was determined that this resident had no vitals. Physician, Director of Nursing (DON), Administrator, and Medical Power of Attorney (MPOA) notified.Further record review of the five day follow up was completed [DATE] and contained the following Director of Nursing (DON) statement: I was notified at approximately 10:30 PM via phone of the incident with Resident #100. I got to the facility at approximately 11:00 PM and went to the three (3) south back hall and interviewed the staff members that were caring for Resident #100 at the time of the incident. Primary care Physician was notified and came to the facility Primary Care Physician (PCP) notified the MPOA of the incident and residents passing at approximately 11:15 PM, local police were notified and did respond on the scene at approximately 1:00 AM. Immediate reporting completed, statements were received from the individuals caring for Resident #100.Review of Resident #100's care plan on [DATE] revealed the following interventions:Resident #100 has limited mobility of her bilateral upper and lower extremities.Be sure Resident #100's call light is within reach and encourage her to use it for assistance as needed. Resident #100 needs prompt response to all requests for assistance. She needs a safe environment with even floors free from spills and/or clutter; adequate light; a working and reachable call light, the bed in low position at night; Side rails as ordered, handrails on walls, personal items within reach.Further record review revealed the following order:Bilateral Bed Assist rails for turning and repositioning. No directions specified for order.During an interview with the DON on [DATE] at 1:45 PM it was determined that on [DATE] all bed mattresses in the facility were checked to ensure they were not moving. When this surveyor asked about the hand rail assist bars being checked she stated they are assessed upon admission/readmission,Quarterly, and with any significant change. During an interview with the Administrator she stated, The beds were sold to us as guaranteed to be 100% entrapment free.Observation on [DATE] at 2:00 PM of the measurements of the bed was one (1) inch and ˆ and one (1) inch and an 8th. FDA guidelines in 4 inches for the entrapment zones did not work with these particular hand rail assists due to resident #100 being found with head wedged between the handrail and the mattress according to the police report, and staff statement given . Physician progress notes [DATE] at 12:30 [NAME] was called by staff and a resident was found with head wedged between hand rail and mattress. Then called by the (Administrators name here). Told her i would be over, was (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	told last checked on at 8:30 PM and was in bed ok. Then at 10:25 PM went in to check and found her on her knees with head in between the rail and mattress. They called (nurses name here) LPN#103 he (the nurse) thought she (Resident #100) was still alive, but when he turned to move Resident #100 he realized she was deceased . Noted arm was also wedged and was discolored and she (Resident #100) had Petechie-(tiny, flat, red, purple, or brown pinprick spots caused by broken capillaries (small blood vessels) leaking blood into the skin) on the face. But he (LPN#103) was able to get Resident #100 back in bed. When I (Doctor) arrived she (resident #100) was in bed I noted mild linear redness bade (L) Left neck outerian. I was then able to talk with (Administrators name here) and (Director of Nursing name here) we went to a separate room and tried to reconstruct how this could happen. It appeared she probably tried to get out of bed (she usually sleeps on her right side per LPN#103's name here) and then somehow got her head wedged and was unable to get free. Staff didn't hear any calling out. Roommate wouldn't been awake either. I then called her (Resident #100) son (who i had been talking with recently due to her having a near syncopal episode (fainting or passing out) and un legible words here. We were able to improve her status with IV & lysis with return to normal NA (sodium) and the day before was back out in the day room with the other residents.) I did tell him she passed but unfortunately there was this scenario. Obviously he was shocked by the manner of death. But as a physician himself (The son) he had some understanding of issues like this. The Administrator will contact the appropriate people and i'll call the death certificate on how to handle this. They will probably sign it. (Dr signature here)DON Statement for the five day follow up report to the FRI: I was notified approximately 10:30 PM via phone of the incident with (Resident #100's name here). I got to the facility at approximately 11:00 PM and i went to the three (3) south back hall and interviewed the staff members that were caring for (Residents name here) at the time of the incident. The primary care physician was notified and came to the facility. (Dr's name here) notified the Medical Power of Attorney (MPOA) (Son of residents #100's name here) od the incident and residents passing at approximately 11:15 PM (Police department name here) were notified and did respond on scene at approximately 1:00 AM. Immediate reporting completed. Statements were received from the individuals caring for (Residents #100's name here) (DON signature here)LPN #103's statement I was in the process of passing meds on the three (3)s back hall when i stepped into the breakroom to order my dinner when (NA #104's name here) came in saying she needed help that she had found (Resident #100's name here) on the side of the bed. Upon entering the room (Resident #100's name here) was found kneeling on the floor next to the bed with her head in between the siderail and mattress. It wasn't until I removed her from that position that it was evident that she had already expired. She was then moved back into her bed and Supervisor was notified. (LPN #103's signature here.)Nurse Aide(NA) # 104's statement I put (Resident #100's name here) to bed around 8:30 PM and went to check her for rounds at around 10:30 PM. Nobody from the room had rang in that time or called out. When i found her i went to get (LPN #103's name here) and she had no pulse. I found her on her knees with her head kind of between the rail and bed with her hands down. I wouldn't say it was lodged but it was between it a little bit.NA #105's statement. Arrived into section four(4) at 9:00 PM did not see resident prior to being found unresponsive. Resident had no rand/yelled out since i arrived to the unit the room mate also did not ring or yell out. When i arrived to the residents room she was found in between the mattress with her head facing down parallel with the bedrail, the resident appeared to be on her knees with her body about a 70 degree angle towards the mattress with her right arm limp/hanging to the ground. (NA #105's signature here) On [DATE] C11 was requested by Sgt Detective (name here) to have officers go to (Facilities name and address here) to investigate a D.O.A (Dead on arrival) at approximately 12:24 AM C11 dispatched my self (officers name here) along with (officers name here). At approximately 12:55 AM officers arrived on scene at (facility's name here). When i arrived on scene i spoke with the manager (administrators name here). She advised a Aide(NA#104) and charge nurse had found (residents 100's name here) DOA inside her room. (Administrators name here) advised the aide found the resident in her room halfway off the bed with (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	her head wedged between the mattress and handrail. After finding her she went and got the Carge Nurse for help getting back into the bed. (Administrators name here) advised that the aide hat ad found her had already left due to her shift ending. (administrators name here)advised that the Charge Nurse (LPN #103's name here) was still here. (administrators name here) escorted us to the 3rd floor where (Resident #100's name here) was residing. While on the 3rd floor, i spoke to the Charge Nurse (LPN#103) I asked (LPN #103's name here) to walk me through what happened. (LPN#!)#'s name here) advised that (NA#104's name here) came and got hi and advised that Resident 100 had fallen out of bed. (LPN#103's name here) advised, when he and (NA#104 name here) got back to the room, they got (Resident #100's name here) back in bed into a resting position and noticed she did not have vitals. (LPN #103s name here) advised he then notified (Administrators name here). (LPN#103's name here) advised the time frame was approximately 10:22PM. He advised the last time anyone had spoken to (Resident #100's name here) was approximately 9:30 PM From the statements from (LPN #103's name here) and (administrators name here) it seems that (resident #100's name here) was attempting to get out of bed and fell back into the bed, wedging her head between the handrail and the mattress. The facility was notified of the Immediate Jeopardy on [DATE] at 5:30 PM. Plan of Correction1. Corrective action for resident affected by the deficient practice:This deficient practice could not be corrected as resident passed away. All beds were assessed toensure proper fit and installation. All beds were confirmed to be installed per manufacturerinstruction.2. Identification of other residents having the potential to be affected by the same deficientpractice:This deficient practice had the potential to affect all residents with assist bars.3. To ensure this deficient practice does not reoccur:All residents with assist bars will be assessed by the interdisciplinary team to determineappropriateness, safety, manufacturer compatibility, and potential entrapment risk. Any devicedetermined to be unsafe, inappropriate, improperly installed, incompatible, or no longerclinically indicated will be immediately removed and alternative interventions implemented asappropriate.All licensed nurses, nursing assistants, therapy staff, maintenance staff, and other appropriatepersonnel will receive education regarding: Assessment prior to use Signed consents Care planning Safety monitoring Safety checks for positioningResidents have the right to refuse; device must not act as a restraintEducation will be completed immediately and prior to the employee's next scheduled shift. Staff who have not completed education will not be permitted to provide care until training iscomplete.4. How the facility will monitor corrective actions to ensure the deficient practice will not recur:The Director of Nursing and/or designee will audit all residents with bed rails or assistive devices weekly for 4 weeks, then monthly for 3 months for:Completion of assessments and care plan updates bed system inspections and maintenance documentation.The plan of correction was accepted on [DATE] at 6:37 PM.The IJ was abated on [DATE] at 11:20 AM

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on staff interviews, observation and document reviews, the facility failed to complete an accurate bed rail assessment for a resident.The current assessment did not fully assess resident's risks/needs for side rails. This was true for Resident #100. and had the potential to affect more than a minimal number of residents residing in the long term care facility. Facility Census: 174. Findings included: a) Resident #100During an interview with Facility Administrator on 05/06/26 at 3:27 PM, she reported new beds had recently been obtained for everyone but bariatric residents in the facility and denied that any resident had been assessed for need of bed rails. Side Rail Safety Assessments are completed for the beds quarterly but not for the need of the side rail as it pertain to specific residents. A review of document entitled GSNH-Side Rail Safety Assessment was reviewed with the following questions that were assessed by looking at the bed and/or an Interdisciplinary Team discussing the residents (not assessing the resident in person) per Director of Nursing on 05/06/26 at approximately 5:00 PM. Assessing the mattress/side rail:1.The bars within the side rails are closely spaced to prevent entrapment resulting from a resident's head passing through openings.2.The mattress-to-bed rail interface prevents the resident from falling between the mattress and side rails and possibly smothering the resident when supine.3. The mattress-to-side rail interface prevent the resident from falling between the mattress and side rail and possibly smothering the resident when laying on their side. 4. The mattress is appropriately sized for the selected bed frame and has not shrunk; there is no space between rail and mattress to permit entrapment of a resident. 5.The mattress does not compress to create gaps between the mattress and side rail when pressure is applied. 6. The space between the side rail and the mattress, and the space and the space between the headboard and the mattress, is filled by an added firm inlay, or the mattress creates an interface with the side rail that prevents a resident from falling between the mattress and side rails.7. Latches on the side rails are stable and will not fall when shaken.8. If an air mattress or overlay is utilized, it does not move or have straps that could entrap a resident or have the effect of pouring a resident into a side rail.9. When a side rail is used, elevation of the head of the bead does not create a gap between the mattress and the side rail.-Interventions/Alternatives1.None indicated2. Bed Alarms3. Side Rails4.Side Rails with Controls5.Low Bed6. Mattress with raised edges7. Decrease time in bed to_____;8.The resident requires a low bed but has difficulty getting into the low bed from a standing position.9. The resident requires a low bed and is in danger of hurting self while trying to get up from the low bed or is in danger of an unsteady transfer after standing up.10. Side Rail pads/Rail liners11. Mats on the floor next to the bed. 12. Restorative plan to increase strength and tolerance.13. Frequent staff monitoring.14. Scheduled toileting.15.Visual and verbal reminder to use the call bell16. Use of pillows and cushions as bed boundary reminder.17. Stuffers to fill the space at the foot/side of bed.