STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525509	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Services Ltd	607 Bronson Rd Seymour, WI 54165

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 3 residents (R) (R6, R27, and R7) of 5 sampled residents had documentation that indicated the residents or their legal representatives were thoroughly informed in advance of the risks and benefits of prescribed psychotropic medication. R6 was prescribed diazepam (a benzodiazepine medication) for a diagnosis of anxiety. The facility did not obtain written consent from R6 for the medication. R27 was prescribed olanzapine (an antipsychotic medication) for nausea and vomiting. The facility did not ensure a written consent form was thoroughly reviewed and completed with R27's Power of Attorney for Healthcare (POAHC). R7 was prescribed lorazepam (an antianxiety medication), buspirone (an anxiolytic medication), and duloxetine (an antidepressant medication). The facility did not ensure a written consent form was thoroughly reviewed and completed with R7's POAHC. Findings include: The facility's undated Nursing Psychotropic Medication policy and procedure indicates: .Psychotropic medications are those medications that affect the mind and/or central nervous system. They are used to treat medical needs and can produce changes in behavior and mood .Consent forms will be signed for all psychotropic medications used in the facility .3. A resident/responsible party will be informed of the physician order for psychotropic medication by the nursing department or Social Services. Reasons for the order, possible side effects, and alternative methods attempted will be explained to the resident/responsible party. 4. A resident/responsible party will sign a consent form for psychotropic drug use. Phone/verbal consent will be used until signed consent can be placed in the chart. Verbal consent should be documented in the medical record as to who gave it and the date. 1. On 5/28/25, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including anxiety and muscle spasms. R6's Minimum Date Set (MDS) assessment, dated 5/13/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R6 had intact cognition. R6 was R6's own decision maker. R6 had a physician order for diazepam 5 milligrams (mg) three times daily for anxiety and muscle spasms with a start date of 12/12/24. The medication contained a black box warning (the strictest warning on the label of prescription drugs or drug products by the Food and Drug Administration (FDA) when there is reasonable evidence of an association of a serious hazard with the drug). (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's medical record did not contain a consent form for diazepam. On 5/28/25 at 2:35 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed a consent form for diazepam was not completed. 3. From 5/27/25 to 5/29/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including dementia and anxiety. R7's MDS assessment, dated 2/26/25, had a BIMS score of 11 out of 15 which indicated R7 had moderate cognitive impairment. R7 was deemed incapacitated on 5/20/24 and had an activated POAHC to assist with healthcare decisions. R7's current physician orders included the following medication with a black box warning: ~ Lorazepam 0.5 mg, give 0.5 mg by mouth two times daily related to anxiety. ~ Bupropion 75 mg, give 1 tablet by mouth two times daily for depression. ~ Duloxetine 20 mg, give 1 tablet by mouth once daily for agitation. R7's medication consent forms for lorazepam, bupropion, and duloxetine that were not initialed or dated on pages 1-3 to indicate R7's POAHC reviewed and understood the risks and benefits of the medication, including side effects and adverse reactions, and alternatives to treatment. The consent forms indicated verbal consent was obtained on 6/4/24 and expired on 8/4/24. The consent forms did not contain signatures after the expiration date of 8/4/24. On 5/28/25 at 12:40 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed R7's medication consent forms were not initialed or dated. DON-B indicated all of the pages should be initialed and dated and R7's POAHC's signature should have been obtained. 2. From 5/27/25 to 5/29/25, Surveyor reviewed R27's medical record. R27 was admitted to the facility on [DATE] and had diagnoses including dementia and malignant neoplasm of the lung. R27's MDS assessment, dated 5/7/25, had a BIMS score of 5 out of 15 which indicated R27 had severe cognitive impairment. R27 had an activated POAHC. R27 was prescribed the following medication with a black box warning: ~ Olanzapine 5 mg, give 1 tablet by mouth once daily for nausea and vomiting (dated 5/1/25). R27's medical record did not contain an Informed Consent for Mediation form for olanzapine. On 5/27/25 at 1:33 PM, Surveyor interviewed NHA-A who verified an Informed Consent for Medication form for olanzapine was not completed.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on staff and resident interview and record review, the facility did not ensure 2 residents (R) (R6 and R17) of 3 residents reviewed for hospitalization received the proper notice of transfer, reason for transfer, location of transfer, appeal rights, name and address with telephone number of the Office of the State Long-Term Care Ombudsman plus notification of discharges/transfers to the Ombudsman. In addition, the facility did not ensure R6 and R17 received written information on the duration of the bed hold policy, the reserve bed payment policy, and the right to return to the facility. R6 was transferred to the Emergency Department (ED) on 5/16/25. R6 was not provided with a written transfer or bed hold notice. In addition, the facility did not notify the Ombudsman of R6's transfer. R17 was transferred to the hospital on 2/14/25. R17's representative was not provided with a written transfer or bed hold notice. In addition, the facility also did not notify the Ombudsman of R17's transfer. Findings include: The facility's Transfer Notices and Bed-Hold Rights Policy, dated 2025, indicates: .The resident and the resident's representative shall be given written notice of the bed-hold option at the time of the hospitalization or therapeutic leave .Medicare/Private Pay: .A copy of the bed-hold policy will be sent with the resident at the time of hospitalization. A copy will also be sent to the responsible party within 24 business hours . 1. From 5/27/25 to 5/29/25, Surveyor reviewed R6's medical record. R6's Minimum Data Set (MDS) assessment, dated 5/14/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R6 had intact cognition. R6 was responsible for R6's healthcare decisions. R6's medical record indicated R6 was transferred to the ED on 5/16/25 due to a toe injury. R6's medical record did not contain a written transfer or bed hold notice. On 5/27/25 at 10:47 AM, Surveyor interviewed R6 who indicated R6 was transferred to the ED due to bumping R6's toe. R6 did not recall if R6 signed a transfer or bed hold notice. On 5/28/25 at 8:57 AM, Surveyor requested the written transfer and bed hold notice for R6's hospital transfer on 5/16/25 from Director of Nursing (DON)-B. On 5/28/25 at 9:41 AM, DON-B indicated DON-B was trying to find R6's transfer and bed hold notice and was contacting the nurse who transferred R6. On 5/29/25 at 10:30 AM, Surveyor interviewed DON-B who showed Surveyor a voicemail text on DON-B's phone, dated 5/28/25, from Registered Nurse (RN)-F. The text message indicated RN-F filled out R6's transfer and bed hold forms, however, RN-F shredded the forms. RN-F indicated RN-F thought transfer and bed hold forms should only to be filled out if a resident was admitted to the hospital. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/25 at 11:21 AM, Surveyor a left message for RN-F but did not receive a return call. 2. From 5/27/25 to 5/29/25, Surveyor reviewed R17's medical record. R17's MDS assessment, dated 5/21/25, had a BIMS score of 9 out of 15 which indicated R17 had moderate cognitive impairment. R17 had an activated Power of Attorney for Healthcare (POAHC). R17's medical record included a transfer and bed hold notice and indicated R17 was transferred to the hospital on 2/14/25 due to cellulitis. The notice indicated verbal notification via phone was completed. R17's medical record did not indicate a written transfer and bed hold notice was given or mailed to R17 or R17's representative. On 5/28/25 at 9:37 AM, Surveyor received R17's written transfer and bed hold notice. DON-B indicated Social Worker (SW)-E ran a discharge report and sent the report to the Ombudsman. On 5/28/25 at 9:58 AM, Surveyor reviewed the facility's February 2025 discharge notifications sent to the Ombudsman and noted R17's name was not on the list. DON-B indicated the facility only notifies the Ombudsman of planned discharges and stated residents who are transferred with a bed hold and will be returning to the facility are not on the notification list. DON-B indicated the facility's transfer and bed hold policy is the same as the forms residents are given during transfers. On 5/29/25 at 9:32 AM, Surveyor interviewed RN-D who indicated when a resident is transferred to the hospital, the nurse is responsible for reviewing the transfer notice and bed hold policy with the resident or their representative and should either obtain verbal consent or have the form signed. RN-D indicated RN-D typically has the resident or their representative sign the form but does not give a copy of the form to the resident or their representative unless a copy is requested. RN-D was not sure if the resident and/or their representative should be given a copy or if a copy should be mailed. On 5/29/25 at 9:35 AM, Surveyor interviewed SW-E who indicated SW-E only notifies residents who have planned discharges. SW-E indicated SW-E sends an end of the month report of planned discharges, deaths, and hospital transfers to the Ombudsman only if the residents are not on a bed hold. SW-E indicated nurses should review and obtain signatures or verbal consent from the resident or their representative. SW-E indicated the resident and/or their representative should be provided with a copy. SW-E did not know if R17 or R17's representative received a copy of R17's transfer and bed hold notice. SW-E also indicated SW-E did not have documentation to indicate transfer or bed hold notices were provided to family and indicated that was the nurses' responsibility. SW-E confirmed based on the regulations, SW-E should have notified the Ombudsman of all transfers and discharges.

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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 staff interview and record review, the facility did not ensure a care plan was revised for 1 resident (R) (R4) of 12 sampled residents. The facility did not revise R4's care plan to include a chronic wound that reopened on 5/25/25. R4's care plan also did not indicate R4 was on enhanced barrier precautions (EBP). Findings include: On 5/29/25 at 1:39 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated facility did not have a care plan policy. On 5/27/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including chronic diastolic heart failure, metabolic encephalopathy, and chronic kidney disease. R4's Minimum Data Set (MDS) assessment, dated 4/23/25, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R4 had moderately impaired cognition. R4 had an activated Power of Attorney for Healthcare (POAHC). R4's care plan, dated 5/19/24, did not indicate R4 had a wound or was on EBP. A progress note, dated 5/25/25 at 2:01 PM, indicated the wound had reopened. An order was requested from the physician to continue with Vashe soak and Nystatin to periwound and cover with gauze. Change every other day. A progress note, dated 5/27/25 at 9:34 PM, indicated the physician approved a request to clean left sacrum with Vashe, apply Nystatin, and cover with gauze and tape. On 5/29/25 at 10:48 AM, Surveyor interviewed Registered Nurse (RN)-I who indicated R4 had a chronic wound that closed on 5/24/25 and reopened on 5/25/25. RN-I indicated the physician was updated on 5/25/25 and orders were received. RN-I confirmed R4's care plan was not updated regarding the wound. RN-I also indicated R4 was placed on EBP on the 5/28/25 PM shift which was not added to R4's care plan. On 5/29/25 at 1:42 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated wound interventions and precautions should have been added to R4's care plan when the wound reopened on 5/25/25.

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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** 2. From 5/27/25 to 5/29/25, Surveyor reviewed R27's medical record. R27 was admitted to the facility on [DATE] and had diagnoses including dementia with malignant neoplasm of the lung. R27's MDS assessment, dated 5/7/25, had a BIMS score of 5 out of 15 which indicated R27 had severe cognitive impairment. R27 had an activated Power of Attorney (POA). A care plan (initiated 1/31/25) indicated R27 was at high risk for falls. R27's medical record indicated R27 fell on 5/11/25, 5/15/25, and 5/18/25 with no noted injuries. R27's care plan did not contain new interventions following the falls. A fall risk assessment, dated 5/19/25, indicated R27 was a high fall risk. On 5/29/25 at 1:33 PM, Surveyor interviewed NHA-A who indicated R27 should have had a new fall intervention added to R27's care plan following each fall. NHA-A verified fall interventions were not added to R27's care plan following the falls noted above. Based on observation, staff interview, and record review, the facility did not ensure the environment was free of accident hazards for 2 residents (R) (R26 and R27) of 4 sampled residents. R26 fell on 5/3/25, 5/10/25, and 5/16/25. The facility did not revise R26's care plan to help prevent future falls. In addition, R26's care plan contained an intervention for a fall mat when R26 was in bed. The intervention was not consistently implemented. R27 fell on 5/11/25, 5/15/25, and 5/18/25. R27's care plan was not updated after the falls and did not include interventions to prevent future falls. Findings include: The facility's undated Nursing Fall Policy and Procedure indicates: The fall report will be thoroughly completed by the nurse and a new fall intervention will be added to the resident's care plan and care card . Once completed, the fall report will be forwarded to the Director of Nursing. 1. From 5/27/25 to 5/29/25, Surveyor reviewed R26's medical record. R26 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, cognitive communication deficit, and difficulty in walking. R26's Minimum Data Set (MDS) assessment, dated 2/26/25, had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R26 had severe cognitive impairment. R26 had an activated Power of Attorney for Healthcare (POAHC). R26's care plan, dated 2/25/24, indicated R26 was at high risk for falls. R26's medical record indicated R26 fell on 5/3/25, 5/10/25, and 5/16/25 with no noted injuries. A fall risk assessment, dated 5/23/25, indicated R26 was a high fall risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/27/25 at 10:22 AM, Surveyor observed R26 asleep in bed with a fall mat on the floor next to R26's bed. On 5/28/25 at 2:03 PM, Surveyor observed R26 asleep in bed and noted R26's fall mat was under the bed. On 5/28/25 at 2:05 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-J who indicated R26's fall mat should be on the floor next to the bed when R26 is in bed. On 5/28/25 at 2:44 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated interventions should be added or revisions should be made to a resident's care plan following a fall. DON-B verified R26 had an intervention for a roll out mat placed at the bedside when R26 was in bed. DON-B verified R26's fall mat should be on the floor next to the bed when R26 is in bed. On 5/29/25 at 10:16 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated staff update DON-B of falls. NHA-A indicated DON-B reviews fall interventions and decides which interventions should be added to the care plan. NHA-A indicated the charge nurse adds interventions in the fall report and DON-B adds the interventions to the care plan the next day. NHA-A confirmed the process was not followed and stated staff are working on correcting the process. On 5/29/25 at 10:59 AM, Surveyor interviewed Registered Nurse (RN)-I who indicated R26 was at high risk for falls. RN-I stated staff complete frequent checks on R26 due to R26's fall history. RN-I indicated R26 did not use a call light for assistance. RN-I also indicated a fall mat was used when R26 was in bed during the day and at night. On 5/29/25 at 1:33 PM, Surveyor interviewed NHA-A who indicated R26 should have had a new fall intervention added to R26's care plan following each fall. NHA-A verified fall interventions were not added to R26's care plan following the falls noted above.

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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 observation, staff interview, and record review, the facility did not provide the necessary respiratory care and services for 1 resident (R) (R21) of 2 sampled residents. R21's oxygen was not turned on per R21's continuous oxygen order. Findings include: On 5/28/25 at 12:49 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated the facility did not have an oxygen use policy. From 5/27/25 to 5/29/25, Surveyor reviewed R21's medical record. R21 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD) and chronic respiratory failure with hypoxia (low level of oxygen). R21's Minimum Data Set (MDS) assessment, dated 3/5/25, had a Brief Interview for Mental Status (BIMS) score of 4 out of 15 which indicated R21 had severe cognitive impairment. R21 had an activated Power of Attorney (POA). R21's medical record contained the following orders: ~ Continuous oxygen no more than 3 liters per minute (LPM) on all shifts to have oxygen saturation at 90% or above (dated 9/6/23). ~ Check skin behind ears for redness or skin breakdown with oxygen tubing change every Tuesday AM shift related to chronic obstructive pulmonary disease (COPD) (dated 5/1/25). ~ Change nasal cannula tubing, concentrator tubing, and nebulizer tube, mouthpiece, and chamber every Tuesday AM shift related to COPD. Make sure to date each (dated 5/1/25). On 5/27/25 at 11:28 AM, Surveyor observed R21 in a wheelchair in the hallway and noted R21 had a nasal cannula connected to a portable oxygen tank. The portable oxygen tank was not turned on and was set at 0. On 5/27/25 at 11:33 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-C who verified R21's portable oxygen tank was set at 0. LPN-C indicated R21's oxygen should be set at 2 liters per minute (LPM) continuously and Certified Nursing Assistants (CNA) were responsible for turning on the oxygen tank unless an adjustment was needed and they should notify the nurse. Surveyor observed LPN-C obtain R21's oxygen saturation level which was at 69% after LPN-C changed R21's oxygen setting to 2 LPM. LPN-C was unsure of R21's oxygen saturation parameter and stated LPN-C would follow-up with Surveyor. On 5/27/25 at 11:40 AM, LPN-C approached Surveyor and indicated R21's oxygen saturation level should be at 90% or above. Surveyor observed LPN-C recheck R21's oxygen saturation level which was at 97% on 2 LPM of oxygen. On 5/28/25 at 12:49 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R21 should use continuous oxygen via nasal cannula.

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on staff interview and record review, the facility did not ensure the minimum required members of the facility's Quality Assessment and Assurance (QAA) committee met at least quarterly. This practice had the potential to affect all 31 residents residing in the facility. The facility did not have documentation that the minimum required members of the QAA committee met for quality assessment and assurance purposes on a quarterly basis. Findings include: On 5/29/25 at 8:56 AM, Surveyor reviewed the facility's QAA committee meeting sign-in sheets for the last four quarters and noted the QAA committee met on 7/19/24, 10/18/24, 1/17/25, and 4/18/25. Surveyor noted the minimum required committee members were not in attendance for two of the QAA meetings (7/19/24 and 4/18/25). The Director of Nursing (DON) who was also the Infection Preventionist (IP) did not attend the 7/19/24 or 4/18/25 QAA meetings. On 5/29/25 at 9:22 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified the DON/IP was not present at the 7/19/24 and 4/18/25 QAA meetings.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection. This practice had the potential to affect more than 4 of the 31 residents residing in the facility. The facility did not have a detailed flow diagram of the facility's water system that identified areas where Legionella could grow. The facility's infection control policies were incomplete and/or did not contain current information. R17 was on EBP due to the presence of non-intact skin after R17's percutaneous endoscopic gastrostomy (PEG) tube (feeding tube via stomach) was removed. Certified Nursing Assistant (CNA)-G and CNA-H did not wear personal protective equipment (PPE) during high-contact resident cares, including changing linens and shaving R17. R4's chronic wound reopened on 5/25/25, however, R4 was not placed on EBP until the 5/28/25 PM shift. Findings include: The facility's undated Legionella Policy and Procedure for Water Management indicates: Purpose: To provide a structured plan of action for the prevention of Legionella growth and spread. To assure the safety of all residents and staff. Policy: To establish a procedure as a guide to check and clean equipment; maintenance staff will initiate general precautions to prevent the growth of Legionella bacteria in water lines and systems .3. A detailed drawing of the building water supply will be maintained by the Building and Grounds Department. The facility's Isolation-Categories of Transmission Based Precautions policy, revised April 2024, indicates: .2. Enhanced barrier precautions (EBP), in addition to standard precautions (SP) .will be implemented for residents with targeted multi-drug resistant organisms (MDRO) infections, indwelling medical devices, and wounds, including as part of a public health containment response. A. Examples of infection requiring EBP include, but are not limited to: 1. Wounds. 2. Any skin opening requiring a dressing. 3. Device care or use; central line, urinary catheter, feeding tube, tracheostomy .c. Gown and Gloves: 1. In addition to SP, staff need to wear a gown and gloves during specific high-contact resident care activities for those identified as being at risk for MDRO transmission. 2. Remove gown and gloves before leaving the room and perform hand hygiene immediately .e. Orange Contact Precaution Sign: 1. When a resident is placed on enhanced barrier precautions an orange sign will be used to alert staff to the implementation of transmission-based precautions. The sign will be placed at the entrance/doorway of the resident's room. 1. On 5/29/25, Surveyor reviewed the facility's Legionella Policy and Procedure for Water Management and noted the policy did not include a detailed flow diagram of the the facility's water system. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525509	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Services Ltd	607 Bronson Rd Seymour, WI 54165

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/29/25 at 10:22 AM, Surveyor interviewed Maintenance Director (MD-K) who did not have a detailed flow diagram of the facility's water system that identified areas where Legionella could grow. MD-K indicated if Legionella control measures were not met, the facility would follow the emergency management contaminated water policy. MD-K did not have corrective actions specific to situations when Legionella control measures were not met. 2. On 5/29/25, Surveyor reviewed the facility's infection control policies and procedures. Surveyor noted the facility's policies were not reviewed and updated annually and also noted the following: ~ The facility's Pneumococcal Vaccines policy, dated March 2023, did not include information about the 15-valent pneumococcal conjugate vaccine (PCV-15) or the 21-valent pneumococcal conjugate vaccine (PCV-21). ~ The facility's Influenza Vaccine policy, dated March 2023, did not address how to protect residents from communicable disease from staff with symptoms of respiratory illness. ~ The facility's Influenza Vaccine and COVID-19 Vaccine Employees policies, dated March 2023, did not address the procedure for staff who refuse vaccinations. ~ The facility's Outbreak of Communicable Diseases policy, dated May 2025, addressed gastroenteritis and acute respiratory infection but did not include information about other communicable diseases. In addition, the policy referenced an outdated State of Wisconsin Department of Health Services Memo re: Reporting and control of Acute Respiratory Illness Outbreaks in Long Term Care Facilities document, dated December 13, 2021. The facility's Isolation-Categories of Transmission Based Precautions, policy, dated April 2024, did not specify which multidrug-resistant organisms (MDROs) were being targeted for enhanced barrier precautions. On 5/29/25 at 2:15 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed the facility's infection prevention policies and procedures were incomplete and needed to be updated. DON-B indicated DON-B planned to update the policies as part of DON-B's Infection Preventionist responsibilities. DON-B indicated DON-B did not have a comprehensive list of communicable diseases that must be reported to the health department and stated DON-B had been reporting communicable diseases based on DON-B's personal knowledge of the reporting requirements. 3. From 5/27/25 to 5/29/25, Surveyor reviewed R17's medical record. R17 was admitted to the facility on [DATE] and had diagnoses including dementia, cellulitis (bacterial skin infection) and dysphagia (difficulty swallowing). R17's Minimum Data Set (MDS) assessment, dated 5/21/25, had a Brief Interview for Mental (BIMS) score of 9 out of 15 which indicated R17 had moderate cognitive impairment. R17 had an activated Power of Attorney for Healthcare (POAHC). On 5/27/25 at 10:17 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-C who indicated R17 was on EBP due to open skin after R17's PEG tube was removed. Surveyor observed an EBP sign and PPE cart outside R17's room. On 5/27/25 at 10:25 AM, Surveyor observed CNA-G and CNA-H change R17's linens and shave R17's face with an electric razor without wearing PPE. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525509	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Services Ltd	607 Bronson Rd Seymour, WI 54165

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/27/25 at 11:50 AM, Surveyor interviewed CNA-H who confirmed CNA-H shaved R17's face, brushed R17's hair, and washed R17's glasses without wearing PPE. CNA-H indicated PPE only needed to be worn when CNA-H was in contact with R17 which was what CNA-H was told. CNA-H indicated R17 was on EBP due to a wound. CNA-H indicated CNA-H should have donned PPE, however, CNA-H did not have contact with R17's wound dressing. CNA-H indicated CNA-H did not think an infection could spread from shaving but would don PPE next time. CNA-H also indicated PPE should be worn during linen changes. On 5/28/25 at 12:53 PM, Surveyor interviewed DON-B who indicated CNA-G and CNA-H should have worn PPE if they completed high risk tasks such as dressing and undressing R17. DON-B indicated shaving was questionable, however, if a resident was on EBP staff should don the appropriate PPE. 4. On 5/27/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including chronic diastolic heart failure, metabolic encephalopathy, and chronic kidney disease. R4's MDS assessment dated [DATE] had a BIMS score of 12 out of 15 which indicated R4 had moderate cognitive impairment. R4 had an activated POAHC. On 5/27/25 at 10:36 AM, Surveyor observed a CNA transfer R4 into bed and reposition R4 without wearing PPE. Surveyor did not observe an EBP sign or PPE cart outside R4's room at that time. On 5/28/25, Surveyor did not observe an EBP sign or PPE cart outside R4's room. On 5/29/25 at 10:44 AM, Surveyor observed an EBP sign and a PPE cart outside R4's room. On 5/29/25 at 10:48 AM, Surveyor interviewed Registered Nurse (RN)-I who indicated R4 was placed on EBP on the 5/28/25 PM shift. RN-I stated EBP should be in place when a wound is identified. RN-I confirmed R4's wound was identified on 5/25/25. On 5/29/25 at 1:42 PM, Surveyor interviewed DON-B who indicated EBP should have been implemented the day R4's wound reopened. DON-B verified R4's wound reopened on 5/25/25 which was when EBP should have been implemented.