DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDI	CAID SERVICES		
					AND TRANSMITTAL TE SURVEY AGENCY		ID: 0Y1X Facility ID: 00123		
1. MEDICARE/MEDICAID PROVIDED (L1) 245393 2.STATE VENDOR OR MEDICAID NO (L2) 308740900	R NO.	3. NAME AND ADDRESS OF FACILITY (L3) GOOD SHEPHERD LUTHERAN H (L4) 800 HOME STREET, BOX 747 (L5) RUSHFORD, MN				 TYPE OF ACT Initial Termination Validation 	-		
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Af	9. Other ter Complaint		
6. DATE OF SURVEY 7/23/2 8. ACCREDITATION STATUS: 0 Unaccredited 0 Unaccredited 1 TJC 2 AOA 3 Other	014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENI 09/30	DING DATE: (L35)		
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	75 (L18)75 (L17)	Complianc 1. A B. Not in Con		gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A	6. Scope of S 7. Medical I	Services Limit Director vom Size		
14. LTC CERTIFIED BED BREAKDOW	751	1	II II	i	15. FACILITY MEETS	· · /			
18 SNF 18/19 SNF	19 SNF	ICF	IID		13. FACILIT F MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)			
75 (L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:		
Gail Sorensen, HFE NE I	I	0	6/23/2014	_(L19) K	amala Fiske-Downing, I	Enforcement Spec	<u>cialist</u> 06/27/2014 (L20)		
PAR	T II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	OFFICE OR SINGLE S	TATE AGENCY			
 19. DETERMINATION OF ELIGIBILI <u>X</u> 1. Facility is Eligible to Pa <u>2</u>. Facility is not Eligible 			IPLIANCE WITH ITS ACT:	H CIVIL	 Statement of Fina Ownership/Contro Both of the Above 	ol Interest Disclosure Str			
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)		
OF PARTICIPATION 12/01/1986	BEGINNINC	6 DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure		<u>JNTARY</u> o Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		o Meet Agreement		
25. LTC EXTENSION DATE: (L27)	•	n of Admissions:	(L44)		03-Risk of Involuntary Terminatic 04-Other Reason for Withdrawal	OTHER	ider Status Change		
	D. Reseniu Si	spension Date:	(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS				
		03001				_			
	(L28)	00001		(L31)	Posted 07/29/14 (
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE	RePosted 08/08/2	2014 Co.			
	(L32)	06/27/2014		(L33)	DETERMINATION APP	ROVAL			



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245393

July 29, 2014

Mr. Tom Lindh, Administrator Good Shepherd Lutheran Home 800 Home Street, Box 747 Rushford, Minnesota 55971

Dear Mr. Lindh:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 24, 2014 the above facility is certified for or recommended for:

75 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 75 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

July 29, 2014

Mr. Tom Lindh, Administrator Good Shepherd Lutheran Home 800 Home Street, Box 747 Rushford, Minnesota 55971

RE: Project Number S5393023

Dear Mr. Lindh:

On June 10, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 30, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 23, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 25, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 30, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 23, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 30, 2014, effective June 24, 2014 and therefore remedies outlined in our letter to you dated June 10, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245393	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/23/2014
Name	e of Facility		Street Address, City, State, Zip Code	
GC	OOD SHEPHERD LUTHERAN HOME		800 HOME STREET, BOX 747 RUSHFORD, MN 55971	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item		(Y5)	Date
ID Prefix Reg. #		Correction Completed 06/24/2014	ID Prefix Reg. #	F0280 483.20(d)(3), 483.10(k)(2	Correction Completed 06/24/2014 2)		fix F0314 . # 483.25(c)		Correction Completed 06/24/2014
LSC		-	LSC				SC		
	F0318 483.25(e)(2)	Correction Completed 06/24/2014			Correction Completed 06/24/2014	ID Pre	fix F0428 . # 483.60(c) SC		Correction Completed 06/24/2014
ID Prefix Reg. # LSC	F0465 483.70(h)	Correction Completed 06/24/2014	_		Correction Completed		fix . # SC		
ID Prefix Reg. # LSC			Reg. #		Correction Completed	Reg	ofix . # SC		Correction Completed
Reg. #			_			_	ofix . # SC		
Reviewed E		-	Date:	Signature of Sur	veyor:			Date:	_ /
State Agen			07/29/20		196	94			7/23/2014
Reviewed E CMS RO	3y Reviewed	зВу	Date:	Signature of Sur	veyor:			Date:	
Followup t	o Survey Completed or 5/30/2014	n:		Check for any Uncor Uncorrected Defic				YES	NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245393	(Y2) Multiple Cons A. Building B. Wing	B. Wing 01 - MAIN BUILDING 01			
Name	e of Facility			Street Address, City, State, Zip Code		
GOOD SHEPHERD LUTHERAN HOME				800 HOME STREET, BOX 747 RUSHFORD, MN 55971		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y	'5)	Date
ID Prefix		Correction Completed 06/12/2014	ID Prefix		Correction Completed 06/12/2014	ID Prefix			Correction Completed
	NFPA 101		-	NFPA 101	_	Reg. #			
LSC	K0062		LSC	K0144	-	LSC			
		Correction			Correction				Correction
ID Des fiss		Completed	ID Des fee		Completed	ID Desfer			Completed
ID Prefix					_				
Reg. # LSC			Reg. # LSC		_	Reg. # LSC			
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #			Reg. #		_	Reg. #			
LSC			LSC		-	LSC			_
		Correction			Correction				Correction
		Completed			Completed				Completed
					_				
Reg. # LSC			Reg. # LSC		_	Reg. # LSC			
ID Prefix		Correction Completed	ID Prefix		Correction Completed	ID Prefix			Correction Completed
Reg. #			Reg. #		_	Reg. #			
LSC			LSC		_				
Reviewed E	By Review	ed By	Date:	Signature of Su	irveyor:	1	[Date:	
State Agen	cy PS/k	fd	07/29/201	25822			06/25/22014		
	By Review	ed By	Date:	Signature of Su	irveyor:		ſ	Date:	
CMS RO									
Followup t	o Survey Completed 5/27/2014	on:		Check for any Unco Uncorrected Defi			the Feelling	YES	NO
			1					-	

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00123	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/23/2014		
Name	e of Facility		Street Address, City, State, Zip Code			
GC	OOD SHEPHERD LUTHERAN HOME		800 HOME STREET, BOX 747 RUSHFORD, MN 55971			

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix	20560	Correction Completed 06/24/2014	ID Prefix		Correction Completed 06/24/2014		ID Prefix	20895		Correction Completed 06/24/2014
	MN Rule 4658.			MN Rule 4658.0405 Sub				MN Rule 4658		
ID Prefix Reg. # LSC	20900 MN Rule 4658.							21530 MN Rule 4658		
ID Prefix Reg. # LSC	21535 MN Rule4658.	Correction Completed 06/24/2014 I315 Subp.1	0		Correction Completed 06/24/2014		ID Prefix Reg. # LSC			
ID Prefix Reg. # LSC			Reg. #				ID Prefix Reg. # LSC			
Reg. #			Reg. #		Correction Completed		Reg. #			
Reviewed B State Agen Reviewed B	cy	eviewed By GN/KFD eviewed By	Date: 07/29/2014 Date:	Signature of Sur I Signature of Sur	-	19694	4		Date: 07/ Date:	23/2014
	o Survey Com 5/30/2 M: REVISIT RE	014		Check for any Uncor Uncorrected Defic Page 1 of 1				the Facility?	YES)Y1X12	NO



Protecting, Maintaining and Improving the Health of Minnesotans

July 29, 2014

Mr. Tom Lindh, Administrator Good Shepherd Lutheran Home 800 Home Street, Box 747 Rushford, Minnesota 55971

Re: Enclosed Reinspection Results - Project Number S5393023

Dear Mr. Lindh:

On July 23, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 30, 2014, with orders received by you on June 11, 2014. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility Licensing and Certification File

DEPARIMENT OF HEALTH A	MEDIC	N SERVICES ARE/MEDICAL TO BE COMPI			AND TRANSM	ITTAL	ICARE & MEDI	ID: 0Y1X Facility ID: 00123
1. MEDICARE/MEDICAID PROVIDER 3 (L1) 245393 2.STATE VENDOR OR MEDICAID NO. (L2) 308740900	NO.	 3. NAME AND ADDRESS OF FACILITY (L3) GOOD SHEPHERD LUTHERAN H (L4) 800 HOME STREET, BOX 747 (L5) RUSHFORD, MN 			HOME (L6) 55	5971	 TYPE OF ACT Initial Termination Validation 	 Recertification CHOW Complaint
 5. EFFECTIVE DATE CHANGE OF OW (L9) 6. DATE OF SURVEY 05/30/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 		7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/II 12 RHC	14 CORF	22 CLIA	7. On-Site Visit 8. Full Survey Aft FISCAL YEAR ENE 09/30	-
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	75 (L18)75 (L17)	Complianc <u>X</u> 1. A B. Not in Con		ram	2. Techni 3. 24 Hou 4. 7-Day 5. Life Sa	ical Personnel ur RN RN (Rural SN afety Code	The Following Require 6. Scope of S 7. Medical D F) 8. Patient Ro 9. Beds/Roo (L12)	Services Limit Director om Size
14. LTC CERTIFIED BED BREAKDOWN	1				15. FACILITY ME	ETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1	861 (j) (1):	(L15)	
75 (L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURV	'EY AGENCY	APPROVAL	Date:
Kyla Einertson, HFE NE I	I	0	06/23/2014	(L19)	Ka <u>mala Fiske-D</u>	Downing, E	Inforcement Spec	<u>cialist</u> 06/27/2014 (L20)
PART	II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR	SINGLE S	TATE AGENCY	
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Partian 2. Facility is not Eligible 			IPLIANCE WITH HTS ACT:	I CIVIL	2. Ow		icial Solvency (HCFA-2. l Interest Disclosure Stn :	
22. ORIGINAL DATE 2	3. LTC AGREE	MENT 24	4. LTC AGREEN	IENT	26. TERMINATI	ON ACTION:		(L30)
OF PARTICIPATION 12/01/1986	BEGINNING	G DATE	ENDING DAT	ΓE	<u>VOLUNTARY</u> 01-Merger, Closur	00		<u>JNTARY</u> o Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction			o Meet Agreement
25. LTC EXTENSION DATE: 2		VE SANCTIONS			03-Risk of Involunt 04-Other Reason fo	2	OTHER	
	A. Suspension	n of Admissions:	(L44)		04-Other Reason in	n windrawar	07-Provi 00-Activ	der Status Change
(L27)	B. Rescind S	uspension Date:	(211)					
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS			
		03001			Posted 06	5/27/2014	4 Co.	
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVAL	DATE				
	(L32)			(L33)	DETERMINA	TION APPF	ROVAL	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES	CENTERS FOR MEDICARE & MEDICAID SERVICES			
MEDICARE/MEDICAID CERTIFICATION AN	D TRANSMITTAL	ID: 0Y1X		
PART I - TO BE COMPLETED BY THE STATE	SURVEY AGENCY	Facility ID: 00123		

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN-24-5393

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4950

June 10, 2014

Mr. Tom Lindh, Administrator Good Shepherd Lutheran Home 800 Home Street, Box 747 Rushford, Minnesota 55971

RE: Project Number S5393023

Dear Mr. Lindh:

On May 30, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

> <u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904

Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 9, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 9, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 30, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 30, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145 Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 06/10/2014 FORM APPROVED

		& MEDICAID SERVICES	·		C	MB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	JUN 20 2014	(X3) DATE SURVEY COMPLETED
		245393	B. WING		MN Dept of Health	05/30/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, C 800 HOME STREET RUSHFORD, MN	ITY, STATE,空炉CODE ,BOX 747	05/30/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH COR	R'S PLAN OF CORRECTIO RECTIVE ACTION SHOULE RENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENT	S	FO	00		
	as your allegation of Department's accept	f correction (POC) will serve f compliance upon the otance. Your signature at the age of the CMS-2567 form will ion of compliance.				
F 279 SS=D	revisit of your facility validate that substar regulations has been your verification.		F 2	79		6/20/14
	A facility must use the to develop, review a comprehensive plan	ne results of the assessment nd revise the resident's i of care.				
	plan for each resider objectives and timet medical, nursing, an	velop a comprehensive care nt that includes measurable ables to meet a resident's d mental and psychosocial ified in the comprehensive		Dee 1	Hottochonest	
	to be furnished to att highest practicable p psychosocial well-be §483.25; and any se be required under §4 due to the resident's	rvices that would otherwise 183.25 but are not provided exercise of rights under ne right to refuse treatment	6/20, ~P7	// 4/		
		T is not met as evidenced				
BORATORY		RISUPPLIER REPRESENTATIVE'S SIGN,	ATURE	ΛΤΙΤΙ	E ministrator	2 (X6) DATE /20/

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.

Tag	Good Shepherd Lutheran Home Plan of Corrections Attachment number 1 JUN 20 2014	Completior Date									
F 279	Corrective Action: R34's Care Plan was reviewed and updated to include her diagnosis of both hypertension and chronic airway obstruction for which she is currently receiving medications. Her care plan now identifies current and/or potential problems that may require specific nursing interventions as a result of these conditions.	5/31/14									
	Identification: All current residents' diagnoses were reviewed for hypertension and chronic airway obstruction. Their care plans were reviewed and updated to include current and/or potential problems that require or may require specific nursing interventions to ensure nursing staff are properly prepared to care for the resident's needs r/t these identified diagnoses.										
	Measures: Current policy and procedure titled Nursing Care Plan was reviewed and found to be accurate. This policy was reviewed during the Nurse Management meeting by the Case Managers, Quality Improvement Coordinator and Director of Nursing. Starting with residents currently due for their quarterly care plan review, each Case Manager will review the resident's current diagnoses and updated their care plan to include all those that pose an actual or potential cause for specific nursing interventions including but not limited to medications/treatments ordered by their provider.										
	Monitoring: All new admissions and current residents due for their quarterly care plan will have their diagnoses cross referenced with their care plan to ensure all medical conditions that cause or have the potential to influence the resident's state of health or his/her ability to function normally are addressed in the care plan monthly x 3 then every other month x3. Findings will be reviewed with QA Committee.										
	Responsible Person: Clinical Case Manager monitored by Quality Improvement Coordinator and Director of Nursing.										

	MENT OF HEALTH							. 0	FORM	: 06/10/ APPRC . 0938-0	VED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUF IDENTIFICATION	PLIER/CLIA	1 1 1		LE CONSTRUCTION	JUN 20 MN Dept of 1 Rochest	ZU14 Health	(X3) DAT	E SURVE IPLETED	
		2453	93	B. WING	i		PCOL 219-328	12	05/	30/2014	4
NAME OF F	PROVIDER OR SUPPLIER	1		L	5	STREET ADDRESS, C	ITY, STATE, ZI	P CODE			<u>.</u>
	HEPHERD LUTHERA				ε	800 HOME STREET	, BOX 747				
					F	RUSHFORD, MN	55971				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIEI (MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREF TAG		(EACH COR	ER'S PLAN OF C RECTIVE ACTI RENCED TO TI DEFICIENCY	ON SHOULD	BE	(X5) COMPLE DATI	TION
F 279	Continued From pa by: Based on interview facility failed to deve plan for monitoring hypertension and cl which the resident i medications for 1 o for unnecessary me Findings include: R34 had been adm admission record d diagnoses of chronic congestive heart fai R34's physician ord orders for Advair (cr and salmeterol a br relaxing muscles in breathing) 500/50 o daily for chronic ain sterile inhalation so combination of albu bronchodilators that and increase air flow (milligrams)/3 ml (m four times daily and for chronic airway o medication used to 12.5 mg by mouth e metoprolol XL (exte used to treat high b mouth every day for Document review of administration recor	v and document r elop a comprehe for signs and sy hronic airway obs s currently receiv f 5 residents (R3- edications. itted on 5/20/10. ated 5/29/14, ide ic airway obstruct ilure and hyperter lers dated 5/27/1- ontains fluticasor onchodilator that the airways to im ne puff by inhalar way obstruction, I lution containing terol and ipratrop t relax muscles ir w to the lungs) 2. nilliliter) one vial b every four hours bstruction, losart treat high blood p every day for hype nded release) (a lood pressure) 50 r hypertension. f R34's medication	nsive care mptoms of struction for ing 4) reviewed R34's ntified tion, nsion. 4, revealed works by nprove tion twice DuoNeb (a a bium that are the airways 5 mg by inhalation a n (a pressure) ertension and medication 0 mg by on e for 5/14,	F 2	279						
FORM CMS-25	puff by inhalation tw 67(02-99) Previous Versions	rice daily, DuoNe			Fac	cility ID: 00123		If continuat	ion sheet	Page 2	

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AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	JUN 20 2	(X3)	DATE SURVEY
			A. BUILI	DING				COMPLETED
		245393	B. WING	ì		MN Dept of Hea	<i>ith</i>	05/30/2014
GOOD S	PROVIDER OR SUPPLIER	N НОМЕ		8	STREET ADDRESS, CIT 100 HOME STREET, RUSHFORD, MN 5	TY, STATE, ZIP CC BOX 747		00/00/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORR	I'S PLAN OF CORF ECTIVE ACTION S ENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	ml one vial by inhala 12.5 mg by mouth events 50 mg by mouth events R34's care plan print addressed chronic a hypertension. During interview on registered nurse (RI plan does not addre or hypertension. During interview on had stated hypertension. During interview on had stated hypertension. During interview on had stated hypertension. Document review of LUTHERAN HOME PROCEDURES NUI revised 11/15/12, rea resident will be evalut following areas: d. M problems are related medication and/or trans- Problem/Needs A pro- significant deviation influencing, or may in of health or his/her a	ation four times daily, losartan every day and metoprolol XL ery day. at date 5/29/14, had not airway obstruction or 5/29/14, at 1:29 p.m., N)-C had stated R34's care ss chronic airway obstruction 5/29/14, at 1:36 p.m., RN-B sion and chronic airway robably be care planned if cations for the diagnoses. the facility GOOD SHEPARD POLICIES AND RSING CARE PLAN dated ad, "1. Assessment Each vated upon admission in the ledical problems - what	F 2	279			······································	6/24/14
SS=D	relief " 483.20(d)(3), 483.10 PARTICIPATE PLAN	(k)(2) RIGHT TO NING CARE-REVISE CP right, unless adjudged	F 28	30				6/24/14 6/20/19 20/19 20/19

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:0Y1X11

Facility ID: 00123

If continuation sheet Page 3 of 24

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<u> </u>	<u>AS FOR MEDICARE</u>		SERVICES	· · · · · · · · · · · · · · · · · · ·						<u>0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICAT	SUPPLIER/CLIA	1		E CONSTRUCTION		2 0 2014 ot of Health	(X3) DATE COM	E SURVEY PLETED
		24	5393	B. WING	ì		Roc	hester	05/3	30/2014
NAME OF F	PROVIDER OR SUPPLIER					TREET ADDRESS, CIT		PCODE		
GOOD S	HEPHERD LUTHERA	N HOME			1	00 HOME STREET, 1 NUSHFORD, MN 55				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		DED BY FULL	ID PREF TAG		(EACH CORRE CROSS-REFERE		ON SHOULD	BE	(X5) COMPLETION DATE
F 280	Continued From pa participate in plann changes in care an A comprehensive c within 7 days after t comprehensive ass interdisciplinary tea physician, a register for the resident, and disciplines as deter and, to the extent p the resident, the re- legal representative and revised by a te each assessment.	ing care and tre d treatment. are plan must the completion sessment; prep m, that include red nurse with d other approp mined by the re racticable, the sident's family e; and periodica	be developed of the bared by an responsibility riate staff in esident's needs, participation of or the resident's ally reviewed	F	280	Sue Att # 2	titchn	-e-t		
	This REQUIREMEI by: Based on observat review, the facility f for 1 of 1 resident (Findings include: On 5/28/14 at 1:55 in wheelchair in cor to open right hand was were moveable. Re denied having pain pointed to right han verbally to question non-verbally by usir sounds. Surveyor of Clinical Manager, (6 right hand, could no	tion, interview a ailed to revise f R6) with contra p.m., R6 was o nmunity area. when asked. T flexed into han 5 can move left when asked, s d. R6 is unables but does atten g left hand, he observed R6 w CM)-A. R6 cou	and document the plan of care actures. bbserved sitting R6 was unable he fingers on d but fingers t hand/arm. R6 hook head and e to respond mpt to respond and vocal orking with ald not open							
FORM CMS-25	67(02-99) Previous Versions		Event ID:0Y1X11		Fac	ility ID: 00123		If continuat	ion sheet	Page 4 of 24

Tag	Good Shepherd Lutheran Home	Correction
	Plan of Corrections	Date
	Attachment number 2	
F 280	Corrective Action: R6 was assessed by her NP on 6/17/14. Orders for restorative ROM have been discontinued d/t R6's current abilities r/t her contractures. NP recommended continuing to incorporate PROM to R6's right extremities during am and pm cares. RN Case Manager updated her orders and care plan to reflect current resident needs.	6/17/14
	Identification: All current residents with known contractures were reassessed by their Case Manager using the newly created Contractures Assessment which specifically instructs them to update resident's current individualized care planned with any changes in interventions to prevent, improve or maintain identified contractures. Those identified have been referred to physical therapy for evaluation and treatment options to ensure appropriate interventions are in place.	6/20/14
	Each resident's care plan will be updated specifically addressing their current needs re: contractures after evaluation.	7/8/14
	Measures: Contracture Assessment added to the list of required assessments completed by the Clinical Case Manager upon admission, hospital return, significant change, and a quarterly for all residents. Case Managers were educated on the above requirements in-service held on 6/24/14.	ölz4/14
	Monitoring: All residents identified as having contractures will have their care plan and current abilities reviewed monthly x 3, then quarterly x 2 for accuracy in ensuring both include the resident needs based on their current abilities.	
	Responsible Person: Clinical Case Manager monitored by Quality Improvement Coordinator and Director of Nursing.	

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		& MEDICAID SERVICES			<u>OWB NC</u>	<u> </u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED	
		245393	B. WING		05	5/30/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STREET ADDRESS, CITY, STREET BODE 800 HOME STREET, BOX 747 RUSHFORD, MN 55971	er de la competition de la competition La competition de la competition de la La competition de la		
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F 280	displayed facial grin The Physician Evalu 4/29/14, lists curren hemiparesis (paraly expressive aphasia The physician's orde gives orders for pas upper and both lowe nights to incorporate toileting and repositi date was 9/24/10. R6's care plan did no ordered by the physi read, "I have occ [oc muscles spasms/cool limited physical mob contractures. Provid	hacing of pain. Jation document dated t diagnoses of: right sis), speechless, and (language disturbance). er sheet signed on 4/19/14, sive range of motion to right er extremities 3 times a day, a range of motion during oning, every shift. Order start ot address range of motion as cian. Care plan dated 3/5/14 coasional] pain r/t [due to] htractures." Also "I have ility r/t right body paresis, e gentle range of motion as	F 2	280			
SS=D	5/29/14 at 10:55 a.m be on the care plan b order." 483.25(c) TREATME PREVENT/HEAL PF Based on the compre- resident, the facility r who enters the facilit does not develop pre- individual's clinical co they were unavoidab pressure sores recei	with the director of nursing on DON stated, "Yes, it should because it is a physician's ENT/SVCS TO ESSURE SORES whensive assessment of a nust ensure that a resident y without pressure sores assure sores unless the bondition demonstrates that le; and a resident having wes necessary treatment and healing, prevent infection and	F 31	14 See Attachment Ht 3	×,	6/24/ 6/20/1 SPN	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00123

If continuation sheet Page 5 of 24

Tag	Good Shepherd Lutheran Home	Completion		
	Plan of Corrections	Date		
	Attachment number 3			
F 314	Corrective Action: A reassessment of R80's skin status was completed on 6/18/14. RN Case Manager inspected for potential vulnerability to pressure related skin conditions. In addition to visually observing resident's skin condition, a lying and sitting tissue tolerance was performed which revealed no current pressure areas. R80's care plan was updated to include a hx of stage I pressure areas located bilaterally on her heels and appropriate interventions to prevent reoccurrence including weekly monitoring performed during her bath.	6/18/14		
	Identification: Case Managers reviewed the skin assessments of all current residents with pressure ulcers for accuracy and updated as needed. Care plans of those identified were reviewed and updated to include interventions to treat and prevent further decline along with interventions to prevent future pressure sores from developing.			
	Measures: Current Pressure Ulcer Protocol was reviewed and updated. During the mandatory Plan of Corrections in-service on 6/24/14 all nursing staff were reeducated on identification and notifications required when a pressure ulcer is identified as well as the required documentation. Floor Nurses were reeducated on daily documentation required following pressure ulcer treatments performed during their shift. EMR was updated to show skin/wound progress notes on the dashboard which is reviewed by the Clinical Case Managers. Wound Nurse will review all pressure ulcers including those identified as being Stage I and make a weekly progress note. Quality Improvement Coordinator added weekly review to Nurse Management/Skin meeting agenda to ensure each identified resident's care plan is updated to include a comprehensive skin assessment for those identified.			
	Monitoring: Quality Improvement Coordinator added weekly review to Nurse Management/Skin meeting agenda to ensure each identified resident's care plan is updated to include a comprehensive skin assessment for those identified. All skin/wound progress notes and treatments will be reviewed weekly x 2 months to ensure Case Manager and Wound Nurse have been notified of identified pressure ulcer.			
	Responsible Person: Floor Nurse, Case Manager and Wound Nurse monitored by Quality Improvement Coordinator and Director of Nursing			

		AND HUMAN SERVICES				FORM	: 06/10/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY IPLETED
		245393	B. WING		MN Dept of Health	05/	/30/2014
NAME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			TREET ADDRESS, CITY, STATE, ZIP CODE	·	
GOOD S	HEPHERD LUTHERA	N HOME			00 HOME STREET, BOX 747 USHFORD, MN 55971		
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F 314	Continued From pa	ige 5	F 3	14			
	by: Based on interview facility failed to com assessment after d pressure ulcers and comprehensive car residents (R80) rev Findings include: R80's admission re identified admitted failure, deficiency a edema. R80's 14 c dated 1/4/14, identi skin treatment turni and application of c one pressure ulcers documented. Document review o 12/30/13, at 3:56 a. right heel red, appro and soft, assisted w heel off mattress ar skin/wound note: in both heels red and with Omnifix tape a further skin/wound noted in progress n both heels after 12/ R80's treatment ad schedule for 12/201 treatment of cover b tape until resolved of	ministration sheets dated 13, 1/14 and 2/14, revealed both heels foam with Omnifix every other day started on					
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:0Y1X11		Fac	ility ID: 00123 If continu	ation shee	t Page 6 of 24

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	13 FUR MEDICARE	& MEDICAID SERVICES						. 0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	JUN 20 2014		E SURVEY IPLETED
		245393	B. WING			MN Dept of Health	05/	30/2014
1	PROVIDER OR SUPPLIER	N HOME	1	8	TREET ADDRESS, CI 00 HOME STREET, RUSHFORD, MN	TY, STATE, ZIP CODE BOX 747	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORF	R'S PLAN OF CORRECT RECTIVE ACTION SHOU RENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 314	2/2/14. However for 16 days of treatment treatment being con Document review of predicting pressure assess 12/22/13 and had been complete pressure areas to be R80's checklist for interventions revea 12/11/13, admit con and discoloration be hospital return com quarterly review con skin intact and idem cognitively impaired living, cardiovascula tolerance and lowel Braden assessment concerns: keep skii each incontinent ep concerns: keep line other risk factors no assessment by lice No assessment had development of pre 12/30/13. Document review of lying revealed date 12/22/13-12/23/13, bruising, edema to skin is thin over bor both hands/wrists a	ast signature for treatment on r the month of 1/14, 10 out of nt had no signatures of mpleted. f R80' s Braden Scale for sore risk revealed dates of nd 3/18/14. No assessment d after development of both heels on 12/30/13. skin risk factors and led dates of completion of nments: skin is intact, bruising ut no open areas, 12/22/13, ments: skin is intact, 3/18/14, mments: Braden equals 20, tified other risk factors d, assist with activities of daily ar disease heart failure, tissue r extremity concerns edema. t interventions: moisture n clean and dry, peri care after pisode, friction and sheer en dry and wrinkle free and of on Braden: weekly skin nsed staff, moisturize dry skin. d been completed after issure areas to both heels on		314				
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FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00123

If continuation sheet Page 7 of 24

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		JUN 20 2014	(X3) DAT	E SURVEY PLETED
		245393	B. WING	I	Rochester	05/	30/2014
	PROVIDER OR SUPPLIER	N HOME		STREET ADDRESS, CI 800 HOME STREET, RUSHFORD, MN \$	BOX 747	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORF	R'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD RENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	addressed bilateral extremities there had documentation in R interventions to pre- getting worse nor p current stage I ulce occurring. During interview on registered nurse (R documented in prog both heels of R80 h areas. RN-A stated there had been nor nurse regarding pre- RN-A stated the phy and family had not areas on heels. RN pressure areas on the discontinued on 2/4 on both heels had r assessments had b development of pre- R80. RN-A verified no skin plan of care ace wraps daily and congestive heart pri looking at the treating the month of 1/2014 treatment for both h treatment being cor seeing RN-A said to During interview on of nursing (DON) had ulcer process: case and family should b	e plan print date 5/29/14, had edema in the lower ad been no other 80's care plan regarding vent pressure areas from reventative measures to heal r or prevent others from 5/29/13, at 8:36 a.m., N)-A verified red area gress note on 12/30/13, on ad been stage one pressure I did not look at heels and documentation by the wound essure areas on R80's heels. ysician or nurse practitioner been notified of the pressure -A stated the treatment for both heels had been /14 when the pressure area esolved. RN-A verified no een completed after the ssure ulcers on both heels of R80's current care plan had other than legs wrapped with t that had been under oblem. RN-A had stated when nent administration record for 4, (10 out of 16 days of neels had no signatures of npleted) I see what you are o the surveyor. 5/29/14, at 9:37 a.m., director ad stated facility pressure manager, dietician, physician e informed when pressure					
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:0Y1X11		Facility ID: 00123	lf continua	uon sheet	Page 8 of 24

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ID PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE		JUN 20 201	4 C	DATE SURVEY	
	PROVIDER OR SUPPLIER	245393	B. WING	STREET ADDF	RESS, WH Period Merain Rochester TREET, BOX 747 D, MN 55971	(747		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X EAC	ROVIDER'S PLAN OF CC CH CORRECTIVE ACTIO S-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 314	ulcer develops. DC would be expected wound nurse to ste stated pressure are weekly until resolve expect treatment to on the treatment re DON verified R80's plan of care other t congestive heart fa care plan to have s previous history of GOOD SHEPARD INTEGRITY/PRES SKIN CARE GUIDI read, "Purpose: To and monitoring pro ulcer care. To preve development by ide factors and implem preventative interve To identify and pror ulcers in an efficien prevent the develop ulcers " 483.25(e)(2) INCRI	N had stated case manager to monitor unless open then up in and monitor. DON had eas should be monitored ed. DON had stated would be completed and signed for cord as set up to be done. current care plan had no skin han ace wraps under ilure and would expect R80's kin plan of care due to pressure ulcers on heels. LUTHERAN SERVICES SKIN SURE ULCER PROTOCOL ELINES dated revised 3/28/13, provide a systemic approach cess for skin integrity/pressure ent pressure ulcer entifying each resident's risk enting appropriate entions for those risk factors. note healing of pressure t and timely manner and pment of additional pressure EASE/PREVENT DECREASE					6/24/	
SS=D	Based on the comp resident, the facility with a limited range	rehensive assessment of a must ensure that a resident		Se	e Detech	Ann	мрŋ	

Tag	Good Shepherd Lutheran Home	Completion					
	Plan of Corrections	Date					
- 240	Attachment number 4 JUN 20 2014						
F 318	Corrective Action: R6 was reassessed by her NP on 6/17/14. Orders for restorative rom have been discontinued. NP reviewed past interventions attempted to increase R6's range of motion s/p CVA. NP recommended providing PROM during cares to minimize discomfort, noting despite previous efforts, R6 fails to make improvement in ROM and declines continue to progress not making her a candidate for a restorative program.	6/17/14					
	Identification:						
	All current residents receiving ROM were reassessed using newly created Contractures Assessment. Those identified as having contractures were referred to physical therapy for an evaluation and recommendations for appropriate treatment options and/or nursing interventions to increase or prevent decrease in their ROM abilities. All those identified have had their care plan reviewed and updated as needed to reflect current intervention plans.						
	Measures:						
	All nursing staff re-educated in the proper techniques used to perform both active and passive range of motion during the Plan of Correction in-service on 6/24/14. Monthly report will be generated by the Household Managers who will collect data to ensure current care planned ROM interventions to prevent further decline are effective and report to the Case Manager when the resident's current plan of care requires adjustments. Data will be noted in newly created template in the resident's EMR. At minimum, Case Managers will perform a comprehensive assessment on each resident quarterly for intervention effectiveness using the gathered information and Contractures Assessment. Director of Nursing will review resident's chart monthly x 6, then every other month x 2.	6/24/14 -509					
	Responsible Person: Household Managers and Case Managers monitored by Director of Nursing.						

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STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DAT	E SURVEY
		245393	B. WING		UN 20 2014	05/	/30/2014
	PROVIDER OR SUPPLIER	N HOME		STREET ADDRESS, CITY, U 800 HOME STREET, BO RUSHFORD, MN 559	X 747 ^{shoster}		<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTIO TIVE ACTION SHOULE CED TO THE APPROP EFICIENCY)) BE	(X5) COMPLETION DATE
	This REQUIREMEN by: Based on observat review, the facility fa motion services as failed to assess the motion and failed to of 1 resident (R6) w Findings include: R6 was observed of was sitting in wheel R6 was observed of was sitting in wheel R6 was unable to op The fingers on R6' r hand but fingers we left hand/arm. R6 d asked, shook head is unable to respond does attempt to resp hand, head and voc observed R6 workin (CM)-A and again R could not straighten facial grimacing of d The Physician Evalu 4/29/14, lists current hemiparesis (paralys expressive aphasia The physician's orde gives orders for pas- upper and both lowe day), nights to incorp toileting and repositi Order start date was	NT is not met as evidenced ion, interview and document alled to provide range of ordered by the physician and resident's need for range of previse the plan of care for 1 ith contractures. In 5/28/14 at 1:55 p.m., R6 and chair in the community area. ben right hand when asked. ight hand was flexed into re moveable. R6 can move enied having pain when and pointed to right hand. R6 d verbally to questions but bond non-verbally by using left al sounds. Surveyor g with Clinical Manager 6 could not open right hand, wrist and also displayed liscomfort. attion document dated t diagnoses of: right sis), speechless, and (language disturbance). er sheet signed on 4/19/14, sive range of motion to right er extremities TID (3 times a porate range of motion during oning, q shift (every shift).	F 3	18			
	7(02-99) Previous Versions (· · · · · · · · · · · · · · · · · · ·		acility ID: 00123	If continuatio	n sheet P	age 10 of 24

		AND HUMAN SERVICES					FORM	: 06/10/201 1APPROVE . 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION G		(X3) DAT	E SURVEY MPLETED
		245393	B. WING	à	JUN 20	2016	05	/30/2014
	PROVIDER OR SUPPLIER HEPHERD LUTHERA	N HOME			STREET ADDRESS, CITY, STATE, 800 HOME STREET, BOX 94/10 RUSHFORD, MN 55971	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
	the physician. Care have occ [occasion spasms/contracture physical mobility r/t contractures." And motion as tolerated POC (Point of Care assistants (NA) incl exercises to right up extremities, apply h stretches to both. G During an interview stated that nursing of right side by stretch also does range of Stated it is done for it fair, has some dis also stated if R6 did motion the resident R6 is not usually me also stated that she R6's hand for 3 yea During an interview p.m., the surveyor g physician's orders for per day) and restora and asked which wa "Restorative orders must have forgottern On 5/29/14 at 10:33 assistant (TMA)-A w stated that she com	otion services as ordered by e plan dated 3/5/14 reads: "I al] pain r/t [due to] muscles es." also "I have limited right body paresis, "Provide gentle range of with daily care.") directions for nursing uded: passive range of motion oper and both lower amstring and heel cord ID (every day). on 5/28/14 at 2:00 p.m., NA-B does range of motion on the ing and moving fingers and motion to right leg daily. 15 minutes and R6 tolerates comfort but not pain. NA-B have pain during range of would report it. NA-B stated edicated before therapy and has not seen a change in rs. with RN-A on 5/28/14 at 2:24 ave RN-A the current signed or range of motion tid (3 times ative nursing orders for daily as correct. RN-A stated, should have been deleted, I to take it out " a.m., the trained medication tho is the household manager municates with RN-A, unit changes or concerns. When	F	318	8			
ORM CMS-25	57(02-99) Previous Versions	Dbsolete Event ID:0Y1X11	-	Fa	acility ID: 00123	If continuatio	on sheet f	Page 11 of 24

STATEMENT OF DEFICIENCIES				IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245393	B. WING		— JUN 20 2014			
NAME OF F	ROVIDER OR SUPPLIEF			STREET ADDRESS, CITY,	MN Dept of Health 05/30/2014			
GOOD SHEPHERD LUTHERAN HOME				800 HOME STREET, BO RUSHFORD, MN 559	OX 747	0002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLET DATE		
F 318	have some discommotion is stopped. does "gentle, relax asked by surveyor TMA-A stated, "It i asked if the nursin anywhere for what resident for range everyone knows th During an interview (DON) on 5/29/14 R6 doesn't like ran incorporated into h often this was don When asked what done, she said," an was aware that or and range of motio physician order sh 3 times per day, an assistant document being done daily of stated she would he the nurse manger stated that range of restorative nursing	stated, "Not very well, she does fort. If she does, range of "Stated that the night shift sing range of motion." When to clarify what that meant, s in the care plan." When g assistants have directions to do specifically for this of motion, TMA-A said, "No, he residents pretty well. " w with the Director of Nursing at 10:45 a.m., DON stated, nge of motion so it is her cares. When asked how e, stated she wasn 't sure. type of range of motion is hkle." DON was asked if she ders for both restorative nursing on are still on the current eet and it is ordered to be done according to nursing ntation range of motion is only r 2 times a day. The DON have expected follow up from to find this discrepancy. DON of motion is not part of	9	8				
F 329	should be on the c "Yes, it should be c physician order."	veyor asked if range of motion are plan. The DON stated, on the care plan because it is a EGIMEN IS FREE FROM DRUGS		9				
	Each resident's dru	ug regimen must be free from						

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245393 NAME OF PROVIDER OR SUPPLIER GOOD SHEPHERD LUTHERAN HOME		(X2) MUL A. BUILD	TIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 05/30/2014 CODE		
		B. WING	P. 23.4 m			
			STREET ADDRESS, CITY, STATE, ZIP C 800 HOME STREET, BOX 747 RUSHFORD, MN 55971			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF	SHOULD BE	(X5) COMPLETION DATE
F 329	Continued From page 12 unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.		F3	See Attach		6/24/
	by: Based on interview facility failed to doc needed (PRN) psyc 1 of 5 residents (R7 medications and the gradual dose reduc antipsychotic and a receiving these two provide a physician contraindicated at t	NT is not met as evidenced y and document review the ument effectiveness for an as chotropic medication used for '2) reviewed for unnecessary e facility failed to attempt a tion and titration of an ntidepressant medication after medications for one year or 's justification why it is his time for 1 of 1 resident (15) Abilify (antipsychotic) and				

Facility ID: 00123

If continuation sheet Page 13 of 24

Tag	Good Shepherd Lutheran Services Plan of Corrections Attachment number 5	Completion 2014 ^{te}						
F 329	Corrective Action:	9.9 <i>4</i> %-						
	Good Shepherd Lutheran Home recognized the importance of ensuring all							
	medications administered cannot be used in excessive dose, for excessive							
	duration, without adequate monitoring, without adequate indications for its							
	use or in the presence of adverse consequences which indicate the dose							
	should be reduced or discontinued or any combination of the above and that							
	gradual dose reductions must be attempted in an effort to discontinue							
	antipsychotic medications unless clinically contraindicated.							
	On 6/17/14 DON reviewed Administering Medications Policy and Procedure							
	which clearly states that part of the required documentation when							
	administering a PRN medication is the results achieved from giving the dose							
	and time results were noted. On 6/18/14 licensed nursing staff who							
	administer medications to R72 were re-educated on our Administering							
	Medication Policy and Procedure specifically discussing follow-up							
	documentation required to show the resident response to the medication							
	administered in order to justify effectiveness and/or provide justification for medication adjustments.							
	R15 was seen by the NP on 6/17/14 for review of her medications including	6/17/14						
	Abilify. A Gradual Dose Reduction was discussed after review of the consultant pharmacist recommendations and noted by her psychiatrist. NP							
	ordered to decrease Abilify and f/u with psychiatrist.							
	Identification:							
	All nurses have the potential of failing to chart results achieved from giving a	6/24/14						
	PRN medication. All nurses were re-educated on the Administering							
	Medication Policy and Procedure during the Plan of Corrections in-service on							
	6/24/14.							
	All residents with current orders for an antipsychotic medication have had	6/20/14						
	their medication reviewed to ensure a gradual dose reduction were							
	performed per regulations unless found to be clinically contraindicated.							
	Measures:							
	All licensed nurses additionally educated on Federal regulation regarding							
	unnecessary medications during the Plan of Corrections in-service on							
	6/24/14. Quality Improvement Coordinator to audit MARs for nurse documentation regarding effectiveness of PRN medication use monthly x 6.							
	Continued monitoring will be implemented depending on results of audit.							
	Pharmacy Consultants contacted and given instruction to contact the primary							
	Case Manager when a gradual dose reduction is indicated and/or when a							
	gradual dose reduction was attempted and required documentation is							
	missing. Case Managers to monitor monthly pharmacy consultant reviews for							

recommendations regarding routine dose reductions. DON will review Case Manager findings with the lead Pharmacy Consultant to achieve compliance monthly x 4. Continued monitoring will be implemented depending on results of audit.
Responsible Person: Licensed Nurses monitored by Quality Improvement Coordinator.
Case Managers and Pharmacy Consultants monitored by Director of Nursing.

		AND HUMAN SERVICES				FORM): 06/10/2014 / APPROVED). 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245393	B. WING		JUN 20 2016	05	/30/2014	
NAME OF PROVIDER OR SUPPLIER				9	STREET ADDRESS, CITY, STATE, ZIP CODE MN DEO HOME STREET, BO K 1499/10			
GOOD SHEPHERD LUTHERAN HOME			RUSHFORD, MN 55971					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 329	Continued From pa	ge 13	FS	329	•			
	however; there was determine if the psy effective and the ph	psychotropic medications not consistent monitoring to vchotropic medication was narmacist had not identified the physician or the director						
	diagnoses including	o the facility on 4/4/14 with g: dementia with behavioral mer's disease and anxiety heet.						
	included PRN order psychotropic medic	ations of "Ativan 0.5 mg th (PO) - TID [three times a						
	medication adminis R72 received PRN 2 3/31/14. The facility	h, April and May 2014 tration record (MAR) showed Ativan 31 times from 3/2/14 to did not document the PRN Ativan 7 of the 31 times administered.						
	4/30/14. Again the effectiveness of the	Ativan 40 times from 4/3/14 to facility did not document the PRN Ativan 12 of the 40 n was administered.						
	5/24/14. Again the	Ativan 5 times from 5/1/14 to facility did not document the PRN Ativan 3 of 5 the times administered.						
		on 5/29/14 at 7:40 a.m., N)-A verified nursing was to						

Event ID:0Y1X11 Facility ID: 00123

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		AND HUMAN SERVICES						FORM	APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING JUN 20 2014							
		245393	B. WING	à		MN Dept of He	4014	05/	30/2014	
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, C	ITY, STATE, ZIF	, CODE			
GOOD S	HEPHERD LUTHERA	N HOME			BOO HOME STREET RUSHFORD, MN					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO DEFICIENC			TION SHOULD BE THE APPROPRIATE		(X5) COMPLETION DATE	
F 329	document the effect psychotropic medic evidenced by the M nursing did not com- effectiveness of the Review of the Admi and Procedures- un Medications: 1. Wh medications, be sur and record of all the (generally on the re a. Date and time m administration and ib. Complaint or sym given c. results achieved results were noted. d. initial or signature On 5/29/14 at 9:52 (DON) stated after her expectation was effectiveness of PR on the MAR or in nu- click care. The DON have documentation effectiveness of the consistent basis. St documentation to b medication was give On 5/29/14 at 11:33 facility was not cons for documenting the medication and an	tiveness of the PRN cation. RN-A verified as IAR and progress notes sistently document the e PRN Ativan for R72. inistering Medications policies ndated read, "PRN teen administering PRN re to document administration e following information everse side of the MAR): edication, dose, route of if, applicable, the injection site. nptoms for which the drug was from giving the dose and time e." a.m., the director of nursing a PRN medication was given s for staff to document the RN psychotropic medications urse progress notes in point N verified the facility did not n of follow up for the e PRN Ativan for R72 on a tated she would expect this e completed each time a PRN en to a resident. B p.m., the DON verified the sistently following their policy e effectiveness of PRN		329						
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:0Y1X	1	Fa	cility ID: 00123		f continuati	on sheet f	Page 15 of 24	

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		AND HUMAN SERVICES					06/10/201 PPROVE)938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TPLE CONSTRUCTION	·	(X3) DATE (COMPL	SURVEY
		245393	B. WING		JUN 20 2014	05/30/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY 800 HOME STREET, E	, STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME		800 HOME STREET, E RUSHFORD, MN 55	1901190 m.		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
	medication titration physician 's justification titration was contrain completed. On 5/28/14 at 2:45 in bed in room doing able to respond to con- just taking an aftern conversation and st sore throat. 5/29/14 at 7:40 a.m. lying in bed and stat going back to sleep 10:00 a.m. Physician notes from degenerative joint di morbid obesity, hype disease, Factor V Le condition), anemia, of Review of Behavior indicates monitoring being done and inter R15's physician order orders for Abilify (an Sertraline (antidepre A progress note was Pharmacist on 4/23/ reduction for Abilify of Dosing and Gradual document rationale for reduction. The form but documentation do	had been attempted or had a ation as to why the GDR and ndicated at this time p.m., R15 was observed lying g a puzzle. R15 was alert and juestions and stated she was oon rest. R15 initiated ated she is battling a cold and ., R15 was observed in room ted she just woke up but was as she usually sleeps until n 3/12/14 lists diagnoses of: isease, cva (stroke), hip pain, ertension, chronic kidney eiden deficiency (blood depression, and renal cyst. Monitoring Book on 5/29/14 for depression symptoms is rventions are listed. er sheet for May 2014 has tipsychotic) 5 mg per day and essant) 150 mg every day.	F 32				

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	NO FUN MEDICANE	& MEDICAID SERVICES	_			OMB N	O. 0938-039	1
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	TIPLE CONSTRUCT	JUN 20 20	(X3) D	ATE SURVEY OMPLETED	
		245393	B. WING			J	5/30/2014	
NAME OF	PROVIDER OR SUPPLIER	4	I	STREET ADDRE	MN Dept of Health SS, CITY, STATE CHECODE	, 0,	5/50/2014	
GOOD S	HEPHERD LUTHERA	NHOME		800 HOME STR RUSHFORD,	REET, BOX 747 MN 55971			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	EACH	DVIDER'S PLAN OF CORRECT I CORRECTIVE ACTION SHOL REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 329 F 428 SS=D	consultant 's progra Gradual Reduction 11/14/12 and 5/6/14 been attempted. Th Medication Quarterl that a gradual dose medications should resident has been o than 6 months. During an interview director of nursing (and procedure for m medications and do quantative charting managers and state psychoactive medica 483.60(c) DRUG RE IRREGULAR, ACT of The drug regimen of	ess note. The Antidepressant Form was completed on but dosage reduction has not be facility's Antipsychotic y Evaluation form indicates reduction of psychoactive be attempted after the in an antipsychotic not more on 5/29/14 at 9:15 a.m., DON) was asked for policy nonitoring psychoactive se reduction. DON stated is done by the nurse id there is no policy for ations and dose reduction. EGIMEN REVIEW, REPORT	F 4					
	the attending physic	st report any irregularities to ian, and the director of eports must be acted upon.		Sec.	Attachanas E Le	t	6/24, spn	114
	by: Based on interview facility failed to ensu identified lack of doc	T is not met as evidenced and document review, the re the consultant pharmacist umentation of effectiveness psychotropic medications						

FORM CMS-2567(02-99) Previous Versions Obsolete

Tag	Good Shepherd Lutheran Services Plan of Corrections Attachment number 6	Completion Date
F 428	Corrective Action: Pharmacy Consultant for R72 was contacted by DON and informed of his failure to identify lack of documentation of effectiveness for this resident's PRN psychotropic medication. DON reviewed the Pharmacy Consultant Service Agreement and confirmed its accuracy in defining Good Shepherd's expectations. DON then reviewed the Agreement with the pharmacy consultant to ensure understanding and future compliance.	6/19/14
	Identification: Pharmacy Consultants were contacted and instructed on the requirement for them to report all irregularities including lack of follow-up documentation for as needed (PRN) medications.	6/20/14
	Measures: DON will review Pharmacy Consultant Recommendations monthly for reported irregularities regarding documentation effectiveness. Licensed nurses will be re-educated on follow-up documentation required to justify use of psychotropic medications during Plan of Corrections in-service on 6/24/14.	6/24/14 DM
	Monitoring: Quality Improvement Coordinator will audit PRN sheets for follow-up documentation compliance by licensed nurses x 6 months. DON will compare audit results to Pharmacy Consultant monthly reviews for accuracy x 3 months. Continued monitoring will be determined by results of audit.	
	Responsible Person: Quality Improvement Coordinator and Director of Nursing	

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STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DA	7. 0938-0391 TE SURVEY MPLETED
		245393	B. WING		JUN 20 2014	05	/30/2014
Ì	PROVIDER OR SUPPLIER	N НОМЕ		80	TREET ADDRESS, MILERS MATERAIP CODE Rochester NOME STREET, BOX 747 RUSHFORD, MN 55971		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	however; there was determine if the psy effective and the ph and reported this to of nursing. R72 was admitted to diagnoses including disturbance, Alzheir state per the face sl R72's current physic included PRN order psychotropic medica [milligrams] by mou day] PRN [as needed Review of the March medication administ R72 received PRN / 3/31/14. The facility effectiveness of the the medication was R72 received PRN / 4/30/14. Again the facility	(R72) reviewed for aations. psychotropic medications not consistent monitoring to rehotropic medication was aarmacist had not identified the physician or the director of the facility on 4/4/14 with g: dementia with behavioral mer's disease and anxiety heet. cian orders dated 4/24/14 s for the following ations of " Ativan 0.5 mg th (PO) - TID [three times a ed]." h, April and May 2014 tration record (MAR) showed Ativan 31 times from 3/2/14 to did not document the PRN Ativan 7 of the 31 times administered. Ativan 40 times from 4/3/14 to facility did not document the PRN Ativan 12 of the 40	F 4	28			
	5/24/14. Again the f	Ativan 5 times from 5/1/14 to acility did not document the PRN Ativan 3 of 5 the times administered.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00123

If continuation sheet Page 18 of 24

	I AND HUMAN SERVICES				FORM	06/10/2014 APPROVED 0938-0391
OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI			(X3) DATE	E SURVEY PLETED
	245393	B. WING		IIIN 2 1 2011	05/3	30/2014
ROVIDER OR SUPPLIER		-	,	CITY, STATE, ZIP CODE		
HEPHERD LUTHERA	N HOME		800 HOME STREET RUSHFORD, MN	, BOW 74pt of Health 55971		
(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K (EACH COF	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
Continued From pa	age 18	F 4	28			
registered nurse (R document the effect psychotropic medic evidenced by the M nursing did not con effectiveness of the Review of the Admi and Procedures- ur Medications: 1. Wh medications, be sur and record of all the (generally on the re a. Date and time m administration and b. Complaint or syn given c. results achieved results were noted. d. initial or signature On 5/29/14 at 9:52 (DON) stated after	nen administering PRN re to document administration e following information everse side of the MAR): redication, dose, route of if, applicable, the injection site. nptoms for which the drug was from giving the dose and time e." a.m., the director of nursing a PRN medication was given					
effectiveness of PF on the MAR or in ni click care. The DOI have documentatio effectiveness of the consistent basis. Si documentation to b medication was giv On 5/29/14 at 11:33 facility was not con- for documenting the	RN psychotropic medications urse progress notes in point N verified the facility did not on of follow up for the PRN Ativan for R72 on a tated she would expect this be completed each time a PRN ren to a resident. 3 p.m., the DON verified the sistently following their policy e effectiveness of PRN					
	medications, be su and record of all th (generally on the re- a. Date and time m administration and b. Complaint or syr given c. results achieved results were noted. d. initial or signatur On 5/29/14 at 9:52 (DON) stated after her expectation wa effectiveness of PF on the MAR or in n click care. The DO have documentation effectiveness of the consistent basis. S documentation to b medication was giv On 5/29/14 at 11:33 facility was not con for documenting th	 Complaint or symptoms for which the drug was given results achieved from giving the dose and time 	medications, be sure to document administration and record of all the following information (generally on the reverse side of the MAR): a. Date and time medication, dose, route of administration and if, applicable, the injection site. b. Complaint or symptoms for which the drug was given c. results achieved from giving the dose and time results were noted. d. initial or signature." On 5/29/14 at 9:52 a.m., the director of nursing (DON) stated after a PRN medication was given her expectation was for staff to document the effectiveness of PRN psychotropic medications on the MAR or in nurse progress notes in point click care. The DON verified the facility did not have documentation of follow up for the effectiveness of the PRN Ativan for R72 on a consistent basis. Stated she would expect this documentation to be completed each time a PRN medication was given to a resident.	medications, be sure to document administration and record of all the following information (generally on the reverse side of the MAR): a. Date and time medication, dose, route of administration and if, applicable, the injection site. b. Complaint or symptoms for which the drug was given b. results achieved from giving the dose and time results were noted. d. initial or signature." On 5/29/14 at 9:52 a.m., the director of nursing (DON) stated after a PRN medication was given her expectation was for staff to document the effectiveness of PRN psychotropic medications on the MAR or in nurse progress notes in point click care. The DON verified the facility did not have documentation of follow up for the effectiveness of the PRN Ativan for R72 on a consistent basis. Stated she would expect this documentation to be completed each time a PRN medication was given to a resident. On 5/29/14 at 11:33 p.m., the DON verified the facility was not consistently following their policy for documenting the effectiveness of PRN	medications, be sure to document administration and record of all the following information (generally on the reverse side of the MAR): a. Date and time medication, dose, route of administration and if, applicable, the injection site. b. Complaint or symptoms for which the drug was given b. results achieved from giving the dose and time results were noted. d. initial or signature." Dn 5/29/14 at 9:52 a.m., the director of nursing (DON) stated after a PRN medication was given her expectation was for staff to document the effectiveness of PRN psychotropic medications on the MAR or in nurse progress notes in point click care. The DON verified the facility did not have documentation of follow up for the effectiveness of the PRN Ativan for R72 on a consistent basis. Stated she would expect this documentation to be completed each time a PRN medication was given to a resident. Dn 5/29/14 at 11:33 p.m., the DON verified the facility was not consistently following their policy for documenting the effectiveness of PRN	medications, be sure to document administration and record of all the following information (generally on the reverse side of the MAR): a. Date and time medication, dose, route of administration and if, applicable, the injection site. b. Complaint or symptoms for which the drug was given b. results achieved from giving the dose and time results were noted. d. initial or signature." On 5/29/14 at 9:52 a.m., the director of nursing (DON) stated after a PRN medication was given her expectation was for staff to document the effectiveness of PRN psychotropic medications on the MAR or in nurse progress notes in point blick care. The DON verified the facility did not nave documentation of follow up for the effectiveness of the PRN Ativan for R72 on a consistent basis. Stated she would expect this documentation to be completed each time a PRN medication was given to a resident.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY MPLETED
		245393	B. WING	i	MN Dept of Hoette	05	/30/2014
	PROVIDER OR SUPPLIER	N НОМЕ		ε	STREET ADDRESS, CITY, STAFE, ZIR CODE 300 HOME STREET, BOX 747 RUSHFORD, MN 55971		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	Agreement (MN) da reviews of the drug written, dated and s	sultant Pharmacist Service ated 8/1/09 read, "6. Monthly regimen of each patient with signed reports of any	F 4	428			
	Director of Nurses. recommendations r administration, inter labs and the potent	will be delivered to the The review shall include regarding aspects of drug ractions, side effects, doses ial for unnecessary drugs as ederal and other appropriate					
F 465 SS=E	consultant pharmac facility to document psychotropic medic residents. 483.70(h)	on 5/29/14 at 12:48 p.m. the sist stated he would expect the the effectiveness of PRN ations administered to	F 4	165			
		ovide a safe, functional, ortable environment for the public.	· · ·		See Attachment		6/24/1
	by: Based on observat review, the facility fa	NT is not met as evidenced ion, interview, and document ailed to ensure 5 of 10 R54, R15, R16) wheelchairs bod repair.			tt= 7		~5P1
	Findings include:						
		5/29/14, at 10:05 a.m., stated the facility system was					

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Facility ID: 00123

Tag	Good Shepherd Lutheran Home Plan of Corrections	Completion
	Attachment number 7	Date
F 465	Corrective Action:	5 2814 14
1 100	R49, R26, R54, R15 and R16 all received a different wheelchair free of alw Dept of defects in the vinyl surfaces.	Health
	Identification: Each primary Case Manager physically inspected each of their resident's wheelchairs for any defects in the vinyl surfaces. All wheelchairs found to have defective surface were referred to the maintenance department for repair or replacement. Replacement parts will be ordered and repairs will be accomplished as parts arrive.	6/20/14
	Measures: Wheelchairs are thoroughly washed on a monthly basis by housekeeping staff. Housekeeping staff will observe for any defects in the vinyl during this monthly inspection and report findings to the maintenance department for repair or replacement. All staff informed during the Plan of Correction inservice on 6/24/14 to immediately report any wheelchair defects to the maintenance department for prompt repair between washings.	6/24/14 ZPN
	Monitoring: Environmental Service Director to monitor housekeeping staff's efficiency in identifying repair needs. Quality Improvement Coordinator to collect audit forms and maintenance slips on a monthly basis x 3 then every other month x 2.	
	Responsible Person: Housekeeping staff monitored by Environmental Service Director and Quality Improvement Coordinator.	

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	NO FUR MEDICARE	& MEDICAID SERVICES					<u>. 0938-0391</u>
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILC		JUN 20 2014		TE SURVEY MPLETED
		245393	B. WING		· · ·	05	/30/2014
	PROVIDER OR SUPPLIER	N HOME		{	MN Dept of Health STREET ADDRESS, CITY, S RAE 218, CODE 800 HOME STREET, BOX 747 RUSHFORD, MN 55971	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 465	Maintenance Work maintenance depar problem with safety needed. M-A stated maintenance staff ir maintenance staff ir maintenance made notified. During int maintenance-B and had no wheelchair r During interview on licensed social work had no policy for ma repairs. LSW-A sta practice was to notif were needed, by co order slip. R49's wheelchair ar cracked vinyl which cleanable surface. During observations R49 sat in a lounge wheelchair beside the time, revealed the w cracked and missing During observations R49 received morni the foot of the bed. revealed right arm re missing vinyl with c wheelchair with sma large area of back o come in contact with missing with cloth est	artment to complete a " Request" a pink slip to notify tment when there was a concerns or repairs were d there were three n the facility. M-A stated repairs as soon as they were erview at that time, Maintenance-C verified they	F	465			

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Facility ID: 00123

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DEPARTMENT	OF HEALTH AN	ID HUMAN	SERVICES
CENTERS FOF	MEDICARE & I	MEDICAID	SERVICES

PRINTED: 06/10/2014 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DA			TE SURVEY MPLETED		
		245393	B. WINC	G_		MN Dopt of Ho		5/30/2014
	PROVIDER OR SUPPLIER	N HOME			STREET ADDRESS, CITY, ST 800 HOME STREET, BOX RUSHFORD, MN 5597	ATE, ZHR GODE, 747	enti -	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	١X	(EACH CORRECT) CROSS-REFERENCE		JLD BE	(X5) COMPLETION DATE
F 465	medical appointme stated he " really w him another wheeld scratched his arms During interview on licensed practical n cracked vinyl and e wheelchair arm res LPN-A stated the fa vinyl. During obser up both arms to rev R26 was identified of Data Set (MDS), an have moderate cog mobility device of w required extensive a locomotion on and of Document review of dated 2/17/14, dired wheel self-short dis wheel to destination During observations R26 was in bed with Observations at tha wheelchair outer lef and upper back of v in contact with resid vinyl with cloth expo time, R26 stated the scratched her arms. During interview on registered nurse (RI wheelchairs should	nts three times a week. R49 rished " the facility would find chair. R49 stated he had on the rough vinyl. 5/29/14, at 8:05 a.m., urse (LPN)-A verified the xposed cloth on both ts and back of wheelchair. ucility needed to replace the vations at that time, R49 held eal no scratches at present. On the quarterly Minimum assessment dated 3/11/14, to nitive impairment, used heelchair and walker, and assistance of 1 staff for off unit. f facility resident care plan ted staff R26, was able to tance but required staff to is. on 5/29/14, at 10:00 a.m., wheelchair by the bedside. t time revealed R26 ' s t arm rest had cracked vinyl vheelchair which would come ent had cracked and missing sed. During interview at that e cracked vinyl had not	F	46	5			

Facility ID: 00123

If continuation sheet Page 22 of 24

PRINTED: 06/10/2014 FORM APPROVED OMB NO. 0938-0391

	H3 I OH MEDICARE					01		. 0930-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION	N 20 2014		E SURVEY IPLETED
		245393	B. WING		MN	Dept of Health	05/	30/2014
	PROVIDER OR SUPPLIER	N HOME	·	80	TREET ADDRESS, CITY, STAT DO HOME STREET, BOX 74 USHFORD, MN 55971	ER ØIP: CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROPF	BE	(X5) COMPLETION DATE
F 465	there had been no vinyl. R54 was observed was sitting in whee wheelchair had cra- missing. Licensed interviewed at 1:40 not aware of the wh that housekeeping chair and both nurs report issues to ma Document review of 2/12/14, indicated t long distances and Care plan identifies short term memory R15 was observed wheelchair in room and pieces of vinyl the arm rest does s or alterations in skii p.m., Registered Ni and stated she was issue and stated th Nurse Manager so Document review of 4/11/14, identifies a daily living). Interve Inspection: I would Observe for rednes cuts, bruises and re The care plan does mobility but does in	26's wheelchair. RN-C stated injury to R26 from the cracked on 5/29/14, at 1:00 p.m., R54 Ichair in hallway. R54's cks and pieces of vinyl Practical Nurse (LPN)-A was p.m., and stated that she was neelchair arm issue and stated is responsible for cleaning the ing and housekeeping can intenance. If R54's care plan dated hat R54 uses a wheelchair for requires assistance of 1 staff. diagnoses of Dementia and impairment. on 5/29/14, R15 was sitting in . Left armrest was cracked were missing. R15 stated that cratch her arm. No scratches n noted at that time. At 1:00 urse (RN)-C was interviewed a unaware of the wheelchair at staff is supposed to alert the they can notify maintenance. If R 15's care plan, dated a deficit in ADL's (activities of entions included: "Skin like my SKIN inspected daily. is, open areas, scratches, eport changes to the Nurse." not address wheelchair dicate R15 needs assistance rechanical lift for all transfers	F	165				

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Facility ID: 00123

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PRINTED: 06/10/2014
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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION		(X3) DA CO	<u>). 0938-0391</u> TE SURVEY MPLETED
		245393	B. WING		JUN 20	2014 ₀₅	/30/2014
	PROVIDER OR SUPPLIER	N НОМЕ		STREET ADDRESS, CITY 800 HOME STREET, B RUSHFORD, MN 559	OX 747 Rochester	ealth	100/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTIC CTIVE ACTION SHOULI NCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 465	was sitting in wheele wheelchair arms ha missing. R16 stated stated that it does h arms intact at that ti (LSW)-A was prese stated she would rep verified that the wheele Document review of 5/2/2014, indicated to alteration in skin inte directed staff to mor redness or irritation needed. Care plan Coumadin (blood the included, "Cares are observed for any alte of mobility; independ	on 5/29/14, at 9:00 a.m., R16 chair in hallway. R16's d cracks and pieces of vinyl d it had to be replaced and urt his arm. Skin on R16's me. Licensed Social Worker, nt during observation and port it to maintenance and belchair arms did need repair. R16's care plan dated that R16 has the potential for egrity and interventions nitor skin condition, report any and apply moisturizer as also addresses use of inner) and interventions of done gently and skin is eration. I have a higher level dent with wheelchair ny activity also puts me at	F 4	165			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:0Y1X11

Facility ID: 00123

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PRINTED: 06/10/2014 FORM APPROVED OMB NO. 0938-0391

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DATE SURV COMPLETE	ΈY
		245393	B. WING		05/27/20	14
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 800 HOME STREET, BOX 747 RUSHFORD, MN 55971		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE COM	X5) PLETION PATE
K 000	INITIAL COMMEN	TS	K	000		
	FIRE SAFETY			Docok		
7-9-14	ALL'EGATION OF DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE CATION OF COMPLIANCE.		POCon 78 6-23-14		
DC. 7.	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS H	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
6-30-14	Minnesota Departr Fire Marshal Divisi Good Shepherd Lu substantial complia participation in Mer Subpart 483.70(a), 2000 edition of Nar Association (NFPA	Survey was conducted by the nent of Public Safety - State on. At the time of this survey, otheran Home was found not in ance with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the tional Fire Protection .) Standard 101, Life Safety ter 19 Existing Health Care.		JUN 1 9 2014		
EVT:	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	THE PLAN OF THE FIRE SAFETY		MN DEPT. OF PUBLIC S STATE FIRE MARSHAL D	AFETY	
R	Health Care Fire Ir State Fire Marshal 445 Minnesota St. St Paul, MN 55101	Division Suite 145				
SORATORY		ber/supplier representative's st	GNATURE	Administrat) DATE 6/17

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 ys 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.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/10/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE COMP	SURVEY
		245393	B. WING		05/2	7/2014
	PROVIDER OR SUPPLIER HEPHERD LUTHERA	N HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 800 HOME STREET, BOX 747 RUSHFORD, MN 55971		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1 .Whitney@state.mn.us	K 00	00		
	THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pr 3. The name and/o responsible for com prevent a reoccurre Good Shepherd Lu building. The buildin different times. The constructed in 1963 Type II(111) constru- was constructed a Type II(111) constru- Because the origina are of the same type construction type a the facility was surv The facility is fully f full corridor smoke corridors and resid- monitored for autor notification. The facility has a ca	RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00123

If continuation sheet Page 2 of 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/10/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		ING 01 - MAIN BUILDING 01	COMPLETED	
		245393	B. WING			27/2014
NAME OF F	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP (ODE	
GOOD SI	HEPHERD LUTHER	AN HOME		800 HOME STREET, BOX 747 RUSHFORD, MN 55971		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE
K 062 M SS=F F	The requirement a NOT MET as evid NFPA 101 LIFE S	at 42 CFR, Subpart 483.70(a) is		100 162 The fire pum test logs w	prun 111 be	6/12/1
	continuously main condition and are	tained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25,		162 The fire pum test logs w monitored bu Franzwa Dire maintenance	Duane dor of The five	
	Based on observed facility failed to make in accordance with NFPA 101, Section 1998 NFPA 25, sec	is not met as evidenced by: ation and staff interview, the aintain the fire sprinkler system in the requirements of 2000 ins 19.3.4.1 and 9.6, as well as action 5-3.2.1. This deficient act all 72 residents.		maintenance. pump test wi performed mo per the Cate Waivers At information (attached).	nthly yovical jailable sheet	
	Findings include:			(adjacted).	•	
	05/27/2014, the re	tween 1:30 PM and 4:30 PM on eview of the 10 minute weekly logs and the week of 3/10/2014				
K 144	Facility Maintenar discovery.	ctice was confirmed by the ice Director (DF) at the time of AFETY CODE STANDARD	к	144		
SS=F		spected weekly and exercised minutes per month in NFPA 99. 3.4.4.1.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00123

		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	OMB NO. (X3) DATE	the second s
		245393	B. WING			27/2014
	PROVIDER OR SUPPLIER	N HOME		STREET ADDRESS, CITY, STATE, ZIP COD 800 HOME STREET, BOX 747 RUSHFORD, MN 55971	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE {EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
К 144	Based on docume interview, the facilit generator in accord 2000 NFPA 101 - 9 Chapter 6-4.1. The all 72 residents. Findings include: On facility tour betw 05/27/2014, docum inspection logs (05 diesel emergency of weekly operational the weeks of 2/3, 2 This deficient prac Director of Mainter discovery.	s not met as evidenced by: ntation review and staff y failed to test the emergency dance with the requirements of 1.3 and 1999 NFPA 110 deficient practice could affect ween 1:30 PM and 4:30 PM on hentation review of the weekly /27/2013 to 05/27/2014) for the generator revealed that the inspections were missed for 2/10 and 2/17/2014. tice was confirmed by the hance (DF) at the time of	К 14	Weekly inspect for the diesel generatore will monitored by (Franzwa Direct Maintenance to compliance.	ion logs e mergancy be) uane or of assure	6/12/1

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00123

Facility Name: GOOD SHEPHERD LUTHERAN HOME

We are in compliance with the following Health Care Facility

Categorical Waivers Available

Y N N/A

- 1. Medical Gas Master Alarms 2012 NFPA 99 5.1.9.4 (K77)
- 2. Openings in Exit Enclosures 2012 NFPA 101 7.1.3.2.1(9)(c) (K33)
 - 3. Emergency Generators and Standby Power Systems 2010 NFPA 110 8.4.2.3 (K144)
 - 4. Doors 2012 NFPA 101 18/19.2.2.2 (K038)
 - 5. Suites 2012 NFPA 101 18/19.2.5.7 (K042)
 - 6. Extinguishing Requirements 2011 NFPA 25 5.3 & 8.3 (K062)
 - 7. Clean Waste & Patient Record Recycling Containers 2012 NFPA 101 18/19.7.5.7.2 (K075)
 - 8. Capacity of Means of Egress 2012 NFPA 101 18/19.2.3.4 (K072)
 - 9. Cooking Facilities -2012 NFPA 101 18/19.3.2.5 (K069)
 - 10. Fireplaces 2012 NFPA 101 18/19.5.2.3 (K067)
 - 11. Combustible decorations on walls, doors and ceilings 2012 NFPA 101 18/19 7.5.6 (K073)
 - 12. Fire/smoke dampers inspected every 6 years HOSPITALS ONLY 2007 NFPA 80 19.4 and 2007 NFPA 105 6.5 (K067)

13. Operating room relativity humidity 2012 NFPA 99 (K078)

Deputy State Fire Marshal Date 05/27/2014 Gary Schroeder

Minneso	ta Department of He	ealth				-
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	
		00123	B. WING		05/3	0/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA		E STREET,			
		RUSHFO	RD, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correputsuant to a surver found that the defice herein are not corrected shall with a schedule of the Minnesota Dep Determination of w corrected requires requirements of the number and MN Rev When a rule contai comply with any of lack of compliance re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department with notice of assessment INITIAL COMMENT On May 27, 28, 29 this Department's st and the following life When corrections at date, make a copy original to the Minn	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance. TS: and 30 2014, surveyors of staff visited the above provider censing orders were issued. are completed, please sign and of these orders and return the esota Department of Health, ance Monitoring, Licensing and		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	

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

TITLE

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00123	B. WING		05/3	0/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
good s	HEPHERD LUTHERA		IE STREET, DRD, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ige 1	2 000			
	Certification Progra Rochester, MN 559	im; 18 Wood Lake Drive SE, 904.		The assigned tag number apper far left column entitled "ID Pre- The state statute/rule out of co- listed in the "Summary Statemed Deficiencies" column and repla Comply" portion of the correction This column also includes the f which are in violation of the state after the statement, "This Rule as evidence by." Following the findings are the Suggested Mer Correction and Time period for PLEASE DISREGARD THE HE THE FOURTH COLUMN WHIC STATES, "PROVIDER'S PLAN CORRECTION." THIS APPLIE FEDERAL DEFICIENCIES ON WILL APPEAR ON EACH PAG THERE IS NO REQUIREMENT SUBMIT A PLAN OF CORRECT	fix Tag." mpliance is ent of ces the "To on order. indings te statute is not met surveyors thod of Correction. EADING OF CH OF ES TO LY. THIS E. T TO TION FOR	
2 560		5 Subp. 2 Comprehensive	2 560	STATUTES/RULES.	OWAL	
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The c must include the inc	of plan of care. The n of care must list measurable stables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557,				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/30/2014	
		00123	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA		ME STREET, B DRD, MN 5597			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 2	2 560			
	by: Based on interview facility failed to dev plan for monitoring hypertension and c which the resident	ent is not met as evidenced and document review, the velop a comprehensive care for signs and symptoms of chronic airway obstruction for is currently receiving of 5 residents (R34) reviewed edications.				
	Findings include:					
	admission record c diagnoses of chron	hitted on 5/20/10. R34's lated 5/29/14, identified hic airway obstruction, hilure and hypertension.				
	orders for Advair (c and salmeterol a b relaxing muscles in breathing) 500/50 c daily for chronic air sterile inhalation so combination of albu bronchodilators tha and increase air flo (milligrams)/3 ml (r four times daily and for chronic airway c medication used to 12.5 mg by mouth metoprolol XL (exte	ders dated 5/27/14, revealed contains fluticasone a steroid ronchodilator that works by in the airways to improve one puff by inhalation twice tway obstruction, DuoNeb (a plution containing a uterol and ipratropium that are at relax muscles in the airways ow to the lungs) 2.5 mg milliliter) one vial by inhalation d every four hours as needed obstruction, losartan (a o treat high blood pressure) every day for hypertension and ended release) (a medication plood pressure) 50 mg by or hypertension.				
	administration recorrevealed R34 had r	of R34's medication ord dated schedule for 5/14, received Advair 500/50 one wice daily, DuoNeb 2.5 mg/3				

If continuation sheet 3 of 29

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA		ME STREET,B DRD, MN 5597 [.]			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 3	2 560			
	ml one vial by inhalation four times daily, losartan 12.5 mg by mouth every day and metoprolol XL 50 mg by mouth every day.		n			
		nt date 5/29/14, had not airway obstruction or				
	registered nurse (R	n 5/29/14, at 1:29 p.m., RN)-C had stated R34's care ess chronic airway obstruction				
	had stated hyperter obstruction should	n 5/29/14, at 1:36 p.m., RN-B nsion and chronic airway probably be care planned if ications for the diagnoses.				
	LUTHERAN HOME PROCEDURES NU revised 11/15/12, re resident will be eva following areas: d. problems are relate medication and/or f Problem/Needs A p significant deviation influencing, or may of health or his/her	of the facility GOOD SHEPARE E POLICIES AND JRSING CARE PLAN dated ead, "1. Assessment Each aluated upon admission in the Medical problems - what ed to each diagnosis, treatment. 2. Care Plan b. problem is defined as any in that has influenced, is now r influence the resident 's state ability to function normally. A a condition requiring supply or	9			
	director of nursing to develop a care p diagnoses along wi program could be e ongoing and effecti	THOD OF CORRECTION: The or designee could direct staff plan to include appropriate ith medications. A monitoring established in order to assure ive care plans and ponse to resident care needs.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SOOD S	HEPHERD LUTHERA		E STREET,B RD, MN 5597 [·]			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	ge 4	2 560			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
2 570	MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p participation of the guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required				
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to revise the plan of care R6) with contractures.				
	Findings include:					
	in wheelchair in cor to open right hand was R6' right hand was were moveable. R6 denied having pain pointed to right han verbally to question non-verbally by usir	p.m., R6 was observed sitting nmunity area. R6 was unable when asked. The fingers on flexed into hand but fingers 6 can move left hand/arm. R6 when asked, shook head and d. R6 is unable to respond s but does attempt to respond ng left hand, head and vocal observed R6 working with				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00123	B. WING		05/	30/2014
NAME OF	PROVIDER OR SUPPLIER	STREET #	ADDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA		ME STREET,B ORD, MN 5597 ⁻			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	Clinical Manager, (right hand, could ne displayed facial grin The Physician Eval 4/29/14, lists curren hemiparesis (paraly expressive aphasia The physician's orc gives orders for pa upper and both low nights to incorporat toileting and reposi date was 9/24/10. R6's care plan did ordered by the phy read, "I have occ [c muscles spasms/c limited physical mo contractures. Provi tolerated with daily During an interview 5/29/14 at 10:55 a. be on the care plan order." SUGGESTED MET director of nursing responsible for acc resident cares and warranted. Also to	CM)-A. R6 could not open ot straighten wrist and macing of pain. luation document dated nt diagnoses of: right ysis), speechless, and a (language disturbance). der sheet signed on 4/19/14, ssive range of motion to right ver extremities 3 times a day, te range of motion during tioning, every shift. Order sta not address range of motion a sician. Care plan dated 3/5/14 occasional] pain r/t [due to] ontractures." Also "I have ubility r/t right body paresis, de gentle range of motion as	rt Is 4 e			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY	
		00123	B. WING	B. WING		05/30/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
GOOD S	HEPHERD LUTHERA		IE STREET,B RD, MN 5597				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 895	Continued From pa	age 6	2 895				
1	MN Rule 4658.052 Motion	5 Subp. 2.B Rehab - Range of	2 895				
	that is directed tow through positioning implemented and r comprehensive res of nursing services development of a r provides that: B. a resident wir receives appropriation	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the sident assessment, the director must coordinate the nursing care plan which th a limited range of motion te treatment and services to motion and to prevent further of motion.					
	by: Based on observat review, the facility f motion services as failed to assess the	ent is not met as evidenced ion, interview and document failed to provide range of ordered by the physician and e resident's need for range of o revise the plan of care for 1 with contractures.					
	R6 was observed of was sitting in whee R6 was unable to of The fingers on R6' hand but fingers we left hand/arm. R6 asked, shook head is unable to respon does attempt to res hand, head and vo	on 5/28/14 at 1:55 p.m., R6 and lichair in the community area. open right hand when asked. right hand was flexed into ere moveable. R6 can move denied having pain when and pointed to right hand. R6 and verbally to questions but spond non-verbally by using lef cal sounds. Surveyor ng with Clinical Manager	5				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00123	B. WING		05/	30/2014
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OOD S	HEPHERD LUTHERA		ME STREET,B DRD, MN 5597 [,]			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 895	Continued From pa	age 7	2 895			
	(CM)-A and again R6 could not open right hand, could not straighten wrist and also displayed facial grimacing of discomfort.					
	4/29/14, lists curren hemiparesis (paral	luation document dated nt diagnoses of: right ysis), speechless, and a (language disturbance).				
	gives orders for pa upper and both low day), nights to inco	der sheet signed on 4/19/14, ssive range of motion to right ver extremities TID (3 times a rporate range of motion during itioning, q shift (every shift). as 9/24/10.	3			
	address range of n the physician. Car have occ [occasion spasms/contractur physical mobility r/t	rehensive care plan did not notion services as ordered by e plan dated 3/5/14 reads: "I nal] pain r/t [due to] muscles es." also "I have limited t right body paresis, d "Provide gentle range of d with daily care."				
	assistants (NA) inc exercises to right u	e) directions for nursing luded: passive range of motion opper and both lower namstring and heel cord QD (every day).	n			
	stated that nursing right side by stretch also does range of Stated it is done fo it fair, has some dis also stated if R6 di motion the residen	v on 5/28/14 at 2:00 p.m., NA-I does range of motion on the ning and moving fingers and motion to right leg daily. r 15 minutes and R6 tolerates scomfort but not pain. NA-B d have pain during range of t would report it. NA-B stated nedicated before therapy and	3			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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AME OF I	PROVIDER OR SUPPLIEF		DRESS, CITY, ST	ATE, ZIP CODE			
		800 HOMI	E STREET, B				
000 2	HEPHERD LUTHER	RUSHFOF	RD, MN 55971	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 895	Continued From p	age 8	2 895				
	also stated that she has not seen a change in R6's hand for 3 years.						
	p.m., the surveyor physician's orders per day) and resto and asked which v	w with RN-A on 5/28/14 at 2:24 gave RN-A the current signed for range of motion tid (3 times prative nursing orders for daily was correct. RN-A stated, is should have been deleted, I en to take it out "					
	assistant (TMA)-A stated that she co manager, regardir asked how R6 tole exercises TMA-A have some discon motion is stopped does "gentle, relax asked by surveyor TMA-A stated, "It i asked if the nursir anywhere for what resident for range	33 a.m., the trained medication who is the household manager mmunicates with RN-A, unit ing changes or concerns. When erates range of motion stated, "Not very well, she does infort. If she does, range of ." Stated that the night shift king range of motion." When to clarify what that meant, is in the care plan." When ing assistants have directions to do specifically for this of motion, TMA-A said, "No, he residents pretty well. "					
	(DON) on 5/29/14 R6 doesn't like rar incorporated into h often this was don When asked what done, she said," a was aware that or and range of motion physician order sh 3 times per day, a assistant document	w with the Director of Nursing at 10:45 a.m., DON stated, nge of motion so it is her cares. When asked how ie, stated she wasn't sure. type of range of motion is nkle." DON was asked if she ders for both restorative nursing on are still on the current heet and it is ordered to be done nd according to nursing ntation range of motion is only or 2 times a day. The DON					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00123	B. WING	B. WING		05/30/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE			
SOOD S	HEPHERD LUTHERA		DME STREET,B FORD, MN 5597 [,]				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 895	Continued From pa	age 9	2 895				
	the nurse manger t	ave expected follow up from to find this discrepancy. DON f motion is not part of duties.					
	10:55 a.m. the survision should be on the ca	with the DON On 5/29/14 at veyor asked if range of motio are plan. The DON stated, on the care plan because it is	n				
	The DON, director could review and re and procedures reg maintaining proper DON, director of th provide an in-servic providing treatmen care. The DON, dir	THOD FOR CORRECTION: of therapy or designee(s) evise as necessary the policie garding implementing and range of motion care. The erapy or designee(s) could ce for all appropriate staff on t per each resident 's plan of rector of therapy or designee soure residents receive proper- tatment.	f (s)				
	TIME PERIOD FO Twenty-One (21)						
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900				
	comprehensive res of nursing services	sores. Based on the sident assessment, the direct must coordinate the nursing care plan which	or				
	without pressure s pressure sores unle	to enters the nursing home ores does not develop ess the individual's clinical rates, and a physician					

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00123	B. WING		05/	05/30/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
GOOD SI	HEPHERD LUTHERA		E STREET, E RD, MN 5597				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	ige 10	2 900				
	authenticates, that	they were unavoidable; and					
	B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.						
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive skin assessment after development of stage one pressure ulcers and failed to develop a comprehensive care plan for skin for 1 of 2 residents (R80) reviewed for pressure ulcers.						
	Findings include:						
	identified admitted failure, deficiency a edema. R80's 14 c dated 1/4/14, identi skin treatment turni and application of c	cord print date of 5/30/14, on 12/6/13, diagnoses of heart nemia, hypertension and day Minimum Data Set (MDS) fied at risk for pressure ulcer, ing and repositioning program dressing to feet, however stage s to both heels had not been					
	12/30/13, at 3:56 a. right heel red, appr and soft, assisted v heel off mattress ar skin/wound note: in both heels red and with Omnifix tape a further skin/wound	of R80's progress notes dated .m., identified skin/wound note oximately 3 cm (centimeters) vith repositioning, elevated nd on 12/30/13, at 3:02 p.m., npaired mobility, pressure, soft, foam placed on bilaterally ind wound nurse notified. No documentation had been	,				
anosota D		otes regarding pressure areas					

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		00123	B. WING	B. WING		30/2014
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
	HEPHERD LUTHERA		NE STREET, B DRD, MN 5597			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 11	2 900			
	schedule for 12/20 treatment of cover tape until resolved 12/30/14 and had I 2/2/14. However for	Aministration sheets dated 13, 1/14 and 2/14, revealed both heels foam with Omnifix every other day started on ast signature for treatment on or the month of 1/14, 10 out of nt had no signatures of mpleted.				
	predicting pressure assess 12/22/13 at had been complete	of R80' s Braden Scale for e sore risk revealed dates of nd 3/18/14. No assessment ed after development of both heels on 12/30/13.				
	interventions revea 12/11/13, admit cor and discoloration b hospital return corr quarterly review cor skin intact and ider cognitively impaire living, cardiovascul tolerance and lowe Braden assessmen concerns: keep ski each incontinent ep concerns: keep line other risk factors n assessment by lice No assessment ha	skin risk factors and aled dates of completion of mments: skin is intact, bruising out no open areas, 12/22/13, mments: skin is intact, 3/18/14, mments: Braden equals 20, ntified other risk factors d, assist with activities of daily lar disease heart failure, tissue er extremity concerns edema. In tinterventions: moisture in clean and dry, peri care after pisode, friction and sheer en dry and wrinkle free and ot on Braden: weekly skin ensed staff, moisturize dry skin d been completed after essure areas to both heels on	r			
	lying revealed date 12/22/13-12/23/13,	of R80's skin assessment tool of completion , comments: abdomen legs, no redness noted, but				

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		00123	B. WING	B. WING		05/30/2014	
ME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
	HEPHERD LUTHERA	N HOME 800 HON	IE STREET, B	OX 747			
000 3		RUSHFC	RD, MN 5597	1			
X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 900	Continued From pa	age 12	2 900				
	both hands/wrists a	ney prominence, bruising to and sitting 12/23/13 comments able relate resident not sitting	:				
	addressed bilateral extremities there had documentation in F interventions to pre getting worse nor p	re plan print date 5/29/14, had l edema in the lower ad been no other 880's care plan regarding event pressure areas from preventative measures to heal er or prevent others from					
	registered nurse (F documented in pro- both heels of R80 f areas. RN-A stated there had been no nurse regarding pro- RN-A stated the ph and family had not areas on heels. RN- pressure areas on discontinued on 2/4 on both heels had assessments had b development of pro- R80. RN-A verified no skin plan of care ace wraps daily and congestive heart pr looking at the treat the month of 1/201 treatment for both	a 5/29/13, at 8:36 a.m., RN)-A verified red area gress note on 12/30/13, on had been stage one pressure I did not look at heels and documentation by the wound essure areas on R80's heels. hysician or nurse practitioner been notified of the pressure I-A stated the treatment for both heels had been 4/14 when the pressure area resolved. RN-A verified no been completed after the essure ulcers on both heels of R80's current care plan had e other than legs wrapped with d that had been under roblem. RN-A had stated when ment administration record for 4, (10 out of 16 days of heels had no signatures of mpleted) I see what you are					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00123	B. WING		05/	30/2014
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
GOOD S	HEPHERD LUTHERA		ME STREET, B DRD, MN 5597			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	age 13	2 900			
	of nursing (DON) h ulcer process: case and family should h ulcer develops. DC would be expected wound nurse to sta stated pressure are weekly until resolve expect treatment to on the treatment re DON verified R80's plan of care other t congestive heart fa care plan to have s previous history of GOOD SHEPARD INTEGRITY/PRES SKIN CARE GUID read, "Purpose: To and monitoring pro- ulcer care. To previde development by ide factors and implem preventative interve- To identify and pro- ulcers in an efficient	ad stated facility pressure e manager, dietician, physician be informed when pressure ON had stated case manager to monitor unless open then ep in and monitor. DON had eas should be monitored ed. DON had stated would be completed and signed for ecord as set up to be done. s current care plan had no skin than ace wraps under ailure and would expect R80's skin plan of care due to pressure ulcers on heels. LUTHERAN SERVICES SKIN SURE ULCER PROTOCOL ELINES dated revised 3/28/13 provide a systemic approach beess for skin integrity/pressure	,			
	The DON or desig	THOD OF CORRECTION: nee could educate staff on				
	The DON or design implement policy a	chensive skin assessments. nee could develop and nd procedure regarding				
	pressure ulcers. Au of pressure ulcers	sessments and care of udits of assessments and care could be done routinely to				
		sive assessments and care idents with pressure ulcers.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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GOOD SI	HEPHERD LUTHERA		IE STREET, B RD, MN 5597			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 14	2 900			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty One				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 4 Tuberculosis ntrol	21426			
	maintain a compre- infection control pro- current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding impleme	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). t include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of e technical assistance ntation of the guidelines. ance with this subdivision must he nursing home.				
	by: Based on interview facility failed to ensist skin test for 1 of 5 for tuberculin skin t Findings include: EE-A personal file results of the first s	ent is not met as evidenced and document review, the sure evidence of tuberculin employees (EE-A) reviewed tests. lacked evidence of reading the step tuberculin skin test and second step tuberculin skin				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00123	B. WING		05/30/2014		
AME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
SOOD S	HEPHERD LUTHERA		ME STREET, BO				
(X4) ID	SUMMARY ST		DRD, MN 55971	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET DATE	
21426	Continued From pa	age 15	21426				
21530	facility New Hire R Document review of form, revealed EE- tuberculin skin test During telephone ir a.m., registered nu hire date of 2/10/14 skin test on 2/10/14 shift of resident cor During telephone ir a.m., RN-B verified personal file lacked step tuberculin skin second step tuberd although the facility provide the skin test provided. Document review of Plan policy updated 1. Prior to assumir employees will hav (tuberculosis) unlest positive reaction an Participation in TB condition of employ skin test conversion by Staff Development test results will be n form and filed in the file. MN Rule 4658.131 A. The drug regiment reviewed at least m currently licensed b	nterview on 5/30/14, at 9:14 rse (RN)-B verified EE-A had 4, received first step tuberculin 4, and verified EE-A's first	n s 3				

6899

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00123	B. WING	B. WING		05/30/2014	
IAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, S	TATE, ZIP CODE		00/2014	
	HEPHERD LUTHERA	800 HO	ME STREET, B				
5000 3	HEFHERD LUTHERA	RUSHF	ORD, MN 5597	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21530	Continued From pa	age 16	21530				
	Surveyor Procedur Requirements in Lo the Department of Health Care Finance This standard is in available through the system. It is not su B. The pharma irregularities to the and the attending p must be acted upon physician visit, or s pharmacist. For pu upon" means the a report and the sign of nursing services C. If the attendor with the pharmacis not provide adequat pharmacist believe being adversely aff refer the matter to if the medical direct physician does not must be referred for assessment and as by part 4658.0070. the medical direct	State Operations Manual, es for Pharmaceutical Servic ong-Term Care, published by Health and Human Services, sing Administration, April 1992 corporated by reference. It is ne Minitex interlibrary loan abject to frequent change. acist must report any director of nursing services obysician, and these reports in by the time of the next ooner, if indicated by the urposes of this part, "acted cceptance or rejection of the ing or initialing by the director and the attending physician. ling physician does not concu- t's recommendation, or does the justification, and the s the resident's quality of life ected, the pharmacist must the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter or review to the quality surance committee required If the attending physician is or, the consulting pharmacist ter directly to the quality	r r s v				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00123	B. WING		05/30/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA		ME STREET,B ORD, MN 5597 ⁻			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 17	21530			
	for as needed (PRI	ocumentation of effectiveness N) psychotropic medications (R72) reviewed for cations.				
	Findings include:					
	however; there was determine if the ps effective and the pl	psychotropic medications s not consistent monitoring to ychotropic medication was harmacist had not identified o the physician or the director				
	diagnoses including	to the facility on 4/4/14 with g: dementia with behavioral imer's disease and anxiety sheet.				
	included PRN orde psychotropic medic	cations of "Ativan 0.5 mg uth (PO) - TID [three times a				
	medication adminis R72 received PRN 3/31/14. The facility	ch, April and May 2014 stration record (MAR) showed Ativan 31 times from 3/2/14 t y did not document the PRN Ativan 7 of the 31 times s administered.	0			
	4/30/14. Again the effectiveness of the	Ativan 40 times from 4/3/14 t facility did not document the PRN Ativan 12 of the 40 on was administered.	0			
	5/24/14. Again the	Ativan 5 times from 5/1/14 to facility did not document the PRN Ativan 3 of 5 the times				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00123	B. WING	B. WING		30/2014
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
	HEPHERD LUTHERA		ME STREET, B			
(X4) ID	SUMMARY ST		DRD, MN 5597	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
21530	Continued From pa	age 18	21530			
	the medication was	s administered.				
	registered nurse (R document the effect psychotropic medic evidenced by the M nursing did not con	on 5/29/14 at 7:40 a.m., RN)-A verified nursing was to ctiveness of the PRN cation. RN-A verified as MAR and progress notes disistently document the e PRN Ativan for R72.				
	and Procedures- un Medications: 1. Wh medications, be su and record of all th (generally on the re a. Date and time m administration and b. Complaint or syn given	nen administering PRN re to document administration e following information everse side of the MAR): nedication, dose, route of if, applicable, the injection site nptoms for which the drug was from giving the dose and time). 5			
	(DON) stated after her expectation wa effectiveness of PF on the MAR or in n click care. The DO have documentation effectiveness of the consistent basis. S	a.m., the director of nursing a PRN medication was given is for staff to document the RN psychotropic medications urse progress notes in point N verified the facility did not on of follow up for the e PRN Ativan for R72 on a tated she would expect this be completed each time a PRN yen to a resident.	1			
	facility was not con	3 p.m., the DON verified the sistently following their policy e effectiveness of PRN 2.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 05/30/2014		
		00123					
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE				
GOOD SI	HEPHERD LUTHERA		NE STREET, B DRD, MN 5597				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21530	Continued From page 19		21530				
	Agreement (MN) da reviews of the drug written, dated and s irregularities noted Director of Nurses. recommendations in administration, inte labs and the potent required by state, for regulatory groups." During an interview consultant pharmac facility to document	sultant Pharmacist Service ated 8/1/09 read, "6. Monthly regimen of each patient with signed reports of any will be delivered to the The review shall include regarding aspects of drug ractions, side effects, doses tial for unnecessary drugs as ederal and other appropriate on 5/29/14 at 12:48 p.m. the cist stated he would expect the t the effectiveness of PRN cations administered to	•				
	The director of nurs develop, review, an procedures to ensu- identifies drug irreg monitoring for effica The director of nurs educate all appropri procedures. The director of nurs	THOD OF CORRECTION: sing (DON) or designee could ad/or revise policies and ure the consultant pharmacist jularities including appropriate acy of medications. sing (DON) or designee could riate staff on the policies and sing (DON) or designee could systems to ensure ongoing					
	TIME PERIOD FOI (21) Days.	R CORRECTION: Twenty-one)				
21535	MN Rule4658.1315 Drug Usage; Gene	5 Subp.1 ABCD Unnecessary ral	21535				
	Subpart 1. Generation	al. A resident's drug regimen					
	epartment of Health						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00123	B. WING		05/	30/2014
AME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE		
OOD SI	IEPHERD LUTHERA		E STREET,B RD, MN 5597 [,]			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLE DATE
21535	Continued From pa	age 20	21535			
	unnecessary drug i A. in excessive therapy; B. for excessive C. without ade D. in the prese which indicate the o discontinued. In addition to the o part 4658.1310, th with provisions in th Code of Federal Ro 483.25 (1) found in Operations Manual Long-Term Care Fa Department of Hea Health Care Finand This standard is ind available through th	quate indications for its use; or ince of adverse consequences dose should be reduced or lrug regimen review required in e nursing home must comply he Interpretive Guidelines for egulations, title 42, section Appendix P of the State I, Guidance to Surveyors for acilities, published by the alth and Human Services, cing Administration, April 1992. corporated by reference. It is he Minitex interlibrary loan ate Law Library. It is not				
	by: Based on interview facility failed to doo needed (PRN) psy 1 of 5 residents (R medications and th gradual dose reduc antipsychotic and a receiving these two provide a physician contraindicated at t	ent is not met as evidenced and document review the cument effectiveness for an as chotropic medication used for 72) reviewed for unnecessary e facility failed to attempt a ction and titration of an antidepressant medication after o medications for one year or b's justification why it is this time for 1 of 1 resident (15) abilify (antipsychotic) and				
	Findings include:					

STATEMEN	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00123	B. WING		05/30/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA		ME STREET,B DRD, MN 5597 [,]			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 21	21535			
	however; there was determine if the ps effective and the pl and reported this to of nursing.	psychotropic medications s not consistent monitoring to ychotropic medication was harmacist had not identified o the physician or the director to the facility on 4/4/14 with				
	diagnoses includin	g: dementia with behavioral imer's disease and anxiety				
	included PRN orde psychotropic medic	cations of "Ativan 0.5 mg uth (PO) - TID [three times a				
	medication adminis R72 received PRN 3/31/14. The facility	ch, April and May 2014 stration record (MAR) showed Ativan 31 times from 3/2/14 to y did not document the PRN Ativan 7 of the 31 times s administered.				
	4/30/14. Again the effectiveness of the	Ativan 40 times from 4/3/14 to facility did not document the PRN Ativan 12 of the 40 on was administered.				
	5/24/14. Again the	Ativan 5 times from 5/1/14 to facility did not document the PRN Ativan 3 of 5 the times administered.				
	registered nurse (F document the effect psychotropic medic	v on 5/29/14 at 7:40 a.m., RN)-A verified nursing was to ctiveness of the PRN cation. RN-A verified as MAR and progress notes				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00123	B. WING		05/30/2014	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
GOOD S	HEPHERD LUTHERA		NE STREET, B			
(X4) ID	SUMMARY ST		DRD, MN 5597	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
21535	Continued From pa	age 22	21535			
		sistently document the PRN Ativan for R72.				
	and Procedures- un Medications: 1. Wh medications, be su and record of all th (generally on the re a. Date and time m administration and b. Complaint or syn given c. results achieved results were noted. d. initial or signatur On 5/29/14 at 9:52 (DON) stated after her expectation wa effectiveness of PF on the MAR or in n click care. The DO have documentation effectiveness of the consistent basis. S	nen administering PRN re to document administration e following information everse side of the MAR): nedication, dose, route of if, applicable, the injection site inptoms for which the drug was from giving the dose and time re." a.m., the director of nursing a PRN medication was given is for staff to document the RN psychotropic medications urse progress notes in point N verified the facility did not on of follow up for the e PRN Ativan for R72 on a tated she would expect this pe completed each time a PRN				
	facility was not con	3 p.m., the DON verified the sistently following their policy e effectiveness of PRN 2.				
	medication and an year and a gradual medication titration physician ' s justific	dose of an antipsychotic antidepressant for the past dose reduction (GDR) or a had been attempted or had a cation as to why the GDR and indicated at this time				

STATEMEN	Ita Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00123	B. WING		05/	05/30/2014	
NAME OF I	PROVIDER OR SUPPLIER	R STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•		
GOOD S	HEPHERD LUTHER		IE STREET, B DRD, MN 5597				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21535	Continued From p	age 23	21535				
	completed.						
	in bed in room doi able to respond to just taking an after	5 p.m., R15 was observed lying ng a puzzle. R15 was alert and questions and stated she was rnoon rest. R15 initiated stated she is battling a cold and					
	lying in bed and st	n., R15 was observed in room ated she just woke up but was p as she usually sleeps until					
	degenerative joint morbid obesity, hy disease, Factor V	om 3/12/14 lists diagnoses of: disease, cva (stroke), hip pain, pertension, chronic kidney Leiden deficiency (blood a, depression, and renal cyst.					
	indicates monitorir	or Monitoring Book on 5/29/14 ng for depression symptoms is terventions are listed.					
	orders for Abilify (a	der sheet for May 2014 has antipsychotic) 5 mg per day and pressant) 150 mg every day.	I				
	Pharmacist on 4/2 reduction for Ability Dosing and Gradu	as made by the Consultant 3/14 recommending a dose y or use of the Antipsychotic al Reduction Form to e for not attempting a dose					
	reduction. The for but documentation recommended gui	m was completed on 5/6/14, did not comply with the delines listed in the pharmacy ress note. The Antidepressant					
	Gradual Reduction 11/14/12 and 5/6/1	n Form was completed on 4 but dosage reduction has no The facility's Antipsychotic					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00123	B. WING		05/30/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, ST	TATE, ZIP CODE		
	HEPHERD LUTHERA		IOME STREET,B IFORD, MN 5597 ⁻			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21535	Continued From pa	age 24	21535			
	that a gradual dose medications should	rly Evaluation form indicates reduction of psychoactive be attempted after the on an antipsychotic not mor				
	director of nursing and procedure for medications and do quantative charting managers and stat	on 5/29/14 at 9:15 a.m., (DON) was asked for policy monitoring psychoactive ose reduction. DON stated is done by the nurse ed there is no policy for cations and dose reduction.				
	The director of nurs in-service all staff r	THOD OF CORRECTION: sing or pharmacist could esponsible for medication u et the requirements as writte g order.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty C	Dne			
21665	MN Rule 4658.140	0 Physical Environment	21665			
	functional, comforta environment, allow	ust provide a safe, clean, able, and homelike physical ing the resident to use is to the extent possible.				
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview, and documer failed to ensure 5 of 10 6, R54, R15, R16) wheelcha good repair.	nt			
	Findings include:					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00123	B. WING		05/30/2014	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		00/2014
	HEPHERD LUTHERA		IE STREET, B			
		RUSHFC	ORD, MN 5597 ⁻			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	age 25	21665			
	maintenance (M)-A for the nursing dep Maintenance Work maintenance depa problem with safety needed. M-A state maintenance staff maintenance staff maintenance made notified. During in maintenance-B and had no wheelchair During interview or licensed social wor had no policy for m repairs. LSW-A sta practice was to not	in the facility. M-A stated e repairs as soon as they were terview at that time, d Maintenance-C verified they				
	R49's wheelchair a	arm rests and back of chair had n was rough to the touch not a	i			
	R49 sat in a lounge wheelchair beside time, revealed the	is on 5/28/14, at 1:30 p.m., e chair in the facility lobby with the chair. Observations at tha wheelchair right arm rest had ng vinyl with cloth exposed.	t			
	R49 received morr the foot of the bed. revealed right arm missing vinyl with wheelchair with sm large area of back	is on 5/29/14, at 7:25 a.m., as ning cares, wheelchair sat at Observations at that time rest of wheelchair cracked and cloth exposed, left arm rest of nall area of cracked vinyl, and of wheelchair which would th resident, vinyl cracked and				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00123	B. WING	B. WING		30/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA		ME STREET,B ORD, MN 5597 [.]			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	age 26	21665			
	that time, R49 stat medical appointme stated he " really whim another wheel scratched his arms During interview or licensed practical r cracked vinyl and e wheelchair arm res LPN-A stated the f vinyl. During obse	exposed. During interview at ed he took the wheelchair to ents three times a week. R49 wished " the facility would find chair. R49 stated he had s on the rough vinyl. n 5/29/14, at 8:05 a.m., nurse (LPN)-A verified the exposed cloth on both sts and back of wheelchair. acility needed to replace the rvations at that time, R49 held veal no scratches at present.				
	Data Set (MDS), a have moderate cog mobility device of v	on the quarterly Minimum n assessment dated 3/11/14, t gnitive impairment, used wheelchair and walker, and assistance of 1 staff for off unit.	o			
	dated 2/17/14, dire	of facility resident care plan octed staff R26, was able to stance but required staff to ns.				
	R26 was in bed wir Observations at the wheelchair outer le and upper back of in contact with resi vinyl with cloth exp	as on 5/29/14, at 10:00 a.m., th wheelchair by the bedside. at time revealed R26 ' s eff arm rest had cracked vinyl wheelchair which would come dent had cracked and missing osed. During interview at that he cracked vinyl had not s.				
	registered nurse (F	n 5/29/14, at 10:00 a.m., RN)-C stated cracked vinyl on d be reported to maintenance				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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IAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST	ATE, ZIP CODE		00/2014
GOOD S	HEPHERD LUTHERA		ME STREET, B ORD, MN 5597			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	age 27	21665			
	cracked vinyl on R2	stated she was not aware of 26's wheelchair. RN-C stated injury to R26 from the cracked				
	was sitting in whee wheelchair had cra missing. Licensed interviewed at 1:40 not aware of the wh that housekeeping	on 5/29/14, at 1:00 p.m., R54 lichair in hallway. R54's licks and pieces of vinyl Practical Nurse (LPN)-A was p.m., and stated that she was heelchair arm issue and stated is responsible for cleaning the sing and housekeeping can aintenance.	s d			
	2/12/14, indicated t long distances and	of R54's care plan dated that R54 uses a wheelchair for requires assistance of 1 staff diagnoses of Dementia and impairment.				
	wheelchair in room and pieces of vinyl the arm rest does s or alterations in ski p.m., Registered N and stated she was issue and stated th	on 5/29/14, R15 was sitting in Left armrest was cracked were missing. R15 stated that scratch her arm. No scratches in noted at that time. At 1:00 lurse (RN)-C was interviewed is unaware of the wheelchair hat staff is supposed to alert the they can notify maintenance.	at S			
	4/11/14, identifies a daily living). Interve Inspection: I would Observe for redness cuts, bruises and re The care plan does mobility but does in	of R 15's care plan, dated a deficit in ADL's (activities of entions included: "Skin d like my SKIN inspected daily ss, open areas, scratches, eport changes to the Nurse." s not address wheelchair ndicate R15 needs assistance nechanical lift for all transfers				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
SOOD S	HEPHERD LUTHERA		1E STREET,B)RD, MN 5597 [.]			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	age 28	21665			
	due to stroke and o	besity.				
	was sitting in whee wheelchair arms ha missing. R16 state stated that it does h arms intact at that it (LSW)-A was prese stated she would reverified that the wh Document review of 5/2/2014, indicated alteration in skin int directed staff to more redness or irritation needed. Care plan Coumadin (blood th included, "Cares ar observed for any all of mobility; indeper mobility/walking so higher risk for bruis SUGGESTED MET The maintenance of visual inspection of wide to ensure whe and cleanable.	on 5/29/14, at 9:00 a.m., R16 lchair in hallway. R16's ad cracks and pieces of vinyl ed it had to be replaced and hurt his arm. Skin on R16's time. Licensed Social Worker, ent during observation and eelchair arms did need repair. of R16's care plan dated that R16 has the potential for tegrity and interventions onitor skin condition, report any and apply moisturizer as a also addresses use of hinner) and interventions re done gently and skin is lteration. I have a higher level adent with wheelchair my activity also puts me at sing." THOD OF CORRECTION: department could include a residents wheelchairs house eelchairs were in good repair R CORRECTION: Twenty One	,			

	D
Minnesota	Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		JUN 20 2014		SURVEY PLETED
		00123	B. WING		MN Dept of Health Rochester	05/3	30/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
GOOD S	HEPHERD LUTHERA		E STREET, RD, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COF	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOUL RENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000				
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.						
		compliance with all rule provided at the tag le number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon my item of multi-part rule will ment of a fine even if the item					
	that may result from orders provided that the Department with	nearing on any assessments non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.					
	this Department's st and the following lice When corrections and date, make a copy coriginal to the Minne	S: and 30 2014, surveyors of aff visited the above provider ensing orders were issued. re completed, please sign and of these orders and return the esota Department of Health, nce Monitoring, Licensing and		documenting th Correction Ord Tag numbers h	partment of Health is ne State Licensing lers using federal so nave been assigned e statutes/rules for N	ftware. to	

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator (X6) DATE 114

STATE FORM

6899

If continuation sheet 1 of 29

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
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2 000	Continued From pa	ige 1	2 000			
	Certification Progra Rochester, MN 559	im; 18 Wood Lake Drive SE, 904.		The assigned tag number apper far left column entitled "ID Pre- The state statute/rule out of co- listed in the "Summary Statemed Deficiencies" column and repla Comply" portion of the correction This column also includes the f which are in violation of the state after the statement, "This Rule as evidence by." Following the findings are the Suggested Mer Correction and Time period for PLEASE DISREGARD THE HE THE FOURTH COLUMN WHIC STATES, "PROVIDER'S PLAN CORRECTION." THIS APPLIE FEDERAL DEFICIENCIES ON WILL APPEAR ON EACH PAG THERE IS NO REQUIREMENT SUBMIT A PLAN OF CORRECT	fix Tag." mpliance is ent of ces the "To on order. indings te statute is not met surveyors thod of Correction. EADING OF CH OF ES TO LY. THIS E. T TO TION FOR	
2 560		5 Subp. 2 Comprehensive	2 560	STATUTES/RULES.	OWAL	
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The c must include the inc	of plan of care. The n of care must list measurable stables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557,				

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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA		ME STREET, B DRD, MN 5597			
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2 560	Continued From pa	age 2	2 560			
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan for monitoring for signs and symptoms of hypertension and chronic airway obstruction for which the resident is currently receiving medications for 1 of 5 residents (R34) reviewed for unnecessary medications.					
	Findings include:					
	admission record c diagnoses of chron	hitted on 5/20/10. R34's lated 5/29/14, identified hic airway obstruction, hilure and hypertension.				
	orders for Advair (c and salmeterol a b relaxing muscles in breathing) 500/50 c daily for chronic air sterile inhalation so combination of albu bronchodilators tha and increase air flo (milligrams)/3 ml (r four times daily and for chronic airway c medication used to 12.5 mg by mouth metoprolol XL (exte	ders dated 5/27/14, revealed contains fluticasone a steroid ronchodilator that works by in the airways to improve one puff by inhalation twice tway obstruction, DuoNeb (a plution containing a uterol and ipratropium that are at relax muscles in the airways ow to the lungs) 2.5 mg milliliter) one vial by inhalation d every four hours as needed obstruction, losartan (a o treat high blood pressure) every day for hypertension and ended release) (a medication plood pressure) 50 mg by or hypertension.				
	administration recorrevealed R34 had r	of R34's medication ord dated schedule for 5/14, received Advair 500/50 one wice daily, DuoNeb 2.5 mg/3				

If continuation sheet 3 of 29

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2 560	Continued From pa	age 3	2 560			
	ml one vial by inhalation four times daily, losartan 12.5 mg by mouth every day and metoprolol XL 50 mg by mouth every day.		n			
		nt date 5/29/14, had not airway obstruction or				
	registered nurse (R	n 5/29/14, at 1:29 p.m., RN)-C had stated R34's care ess chronic airway obstruction				
	had stated hyperter obstruction should	n 5/29/14, at 1:36 p.m., RN-B nsion and chronic airway probably be care planned if ications for the diagnoses.				
	LUTHERAN HOME PROCEDURES NU revised 11/15/12, re resident will be eva following areas: d. problems are relate medication and/or f Problem/Needs A p significant deviation influencing, or may of health or his/her	of the facility GOOD SHEPARE E POLICIES AND JRSING CARE PLAN dated ead, "1. Assessment Each aluated upon admission in the Medical problems - what ed to each diagnosis, treatment. 2. Care Plan b. problem is defined as any in that has influenced, is now r influence the resident 's state ability to function normally. A a condition requiring supply or	9			
	director of nursing to develop a care p diagnoses along wi program could be e ongoing and effecti	THOD OF CORRECTION: The or designee could direct staff plan to include appropriate ith medications. A monitoring established in order to assure ive care plans and ponse to resident care needs.				

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2 560	Continued From pa	ge 4	2 560			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
2 570	MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p participation of the guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required				
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to revise the plan of care R6) with contractures.				
	Findings include:					
	in wheelchair in cor to open right hand was R6' right hand was were moveable. R6 denied having pain pointed to right han verbally to question non-verbally by usir	p.m., R6 was observed sitting nmunity area. R6 was unable when asked. The fingers on flexed into hand but fingers 6 can move left hand/arm. R6 when asked, shook head and d. R6 is unable to respond s but does attempt to respond ng left hand, head and vocal observed R6 working with				

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2 570	Clinical Manager, (right hand, could ne displayed facial grin The Physician Eval 4/29/14, lists curren hemiparesis (paraly expressive aphasia The physician's orc gives orders for pa upper and both low nights to incorporat toileting and reposi date was 9/24/10. R6's care plan did ordered by the phy read, "I have occ [c muscles spasms/c limited physical mo contractures. Provi tolerated with daily During an interview 5/29/14 at 10:55 a. be on the care plan order." SUGGESTED MET director of nursing responsible for acc resident cares and warranted. Also to	CM)-A. R6 could not open ot straighten wrist and macing of pain. luation document dated nt diagnoses of: right ysis), speechless, and a (language disturbance). der sheet signed on 4/19/14, ssive range of motion to right ver extremities 3 times a day, te range of motion during tioning, every shift. Order sta not address range of motion a sician. Care plan dated 3/5/14 occasional] pain r/t [due to] ontractures." Also "I have ubility r/t right body paresis, de gentle range of motion as	rt Is 4 e			

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2 895	Continued From pa	age 6	2 895			
2 895	MN Rule 4658.052 Motion	5 Subp. 2.B Rehab - Range of	2 895			
	that is directed tow through positioning implemented and r comprehensive res of nursing services development of a r provides that: B. a resident wir receives appropriation	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the sident assessment, the director must coordinate the nursing care plan which th a limited range of motion te treatment and services to motion and to prevent further of motion.				
	by: Based on observat review, the facility f motion services as failed to assess the	ent is not met as evidenced ion, interview and document failed to provide range of ordered by the physician and e resident's need for range of o revise the plan of care for 1 with contractures.				
	R6 was observed of was sitting in whee R6 was unable to of The fingers on R6' hand but fingers we left hand/arm. R6 asked, shook head is unable to respon does attempt to res hand, head and vo	on 5/28/14 at 1:55 p.m., R6 and lichair in the community area. open right hand when asked. right hand was flexed into ere moveable. R6 can move denied having pain when and pointed to right hand. R6 and verbally to questions but spond non-verbally by using lef cal sounds. Surveyor ng with Clinical Manager	5			

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2 895	Continued From pa	age 7	2 895			
		R6 could not open right hand, n wrist and also displayed discomfort.				
	4/29/14, lists curren hemiparesis (paral	luation document dated nt diagnoses of: right ysis), speechless, and a (language disturbance).				
	gives orders for pa upper and both low day), nights to inco	der sheet signed on 4/19/14, ssive range of motion to right ver extremities TID (3 times a rporate range of motion during itioning, q shift (every shift). as 9/24/10.	3			
	address range of n the physician. Car have occ [occasion spasms/contractur physical mobility r/t	rehensive care plan did not notion services as ordered by e plan dated 3/5/14 reads: "I nal] pain r/t [due to] muscles es." also "I have limited t right body paresis, d "Provide gentle range of d with daily care."				
	assistants (NA) inc exercises to right u	e) directions for nursing luded: passive range of motion opper and both lower namstring and heel cord QD (every day).	n			
	stated that nursing right side by stretch also does range of Stated it is done fo it fair, has some dis also stated if R6 di motion the residen	v on 5/28/14 at 2:00 p.m., NA-I does range of motion on the ning and moving fingers and motion to right leg daily. r 15 minutes and R6 tolerates scomfort but not pain. NA-B d have pain during range of t would report it. NA-B stated nedicated before therapy and	3			

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		800 HOMI	E STREET, B				
000 2	HEPHERD LUTHER	RUSHFOF	RD, MN 55971	1			
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2 895	Continued From p	age 8	2 895				
	also stated that she has not seen a change in R6's hand for 3 years.						
	p.m., the surveyor physician's orders per day) and resto and asked which v	w with RN-A on 5/28/14 at 2:24 gave RN-A the current signed for range of motion tid (3 times prative nursing orders for daily was correct. RN-A stated, is should have been deleted, I en to take it out "					
	assistant (TMA)-A stated that she co manager, regardir asked how R6 tole exercises TMA-A have some discon motion is stopped does "gentle, relax asked by surveyor TMA-A stated, "It i asked if the nursir anywhere for what resident for range	33 a.m., the trained medication who is the household manager mmunicates with RN-A, unit ing changes or concerns. When erates range of motion stated, "Not very well, she does infort. If she does, range of ." Stated that the night shift king range of motion." When to clarify what that meant, is in the care plan." When ing assistants have directions to do specifically for this of motion, TMA-A said, "No, he residents pretty well. "					
	(DON) on 5/29/14 R6 doesn't like rar incorporated into h often this was don When asked what done, she said," a was aware that or and range of motion physician order sh 3 times per day, a assistant document	w with the Director of Nursing at 10:45 a.m., DON stated, nge of motion so it is her cares. When asked how ie, stated she wasn't sure. type of range of motion is nkle." DON was asked if she ders for both restorative nursing on are still on the current heet and it is ordered to be done nd according to nursing ntation range of motion is only or 2 times a day. The DON					

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2 895	Continued From pa	age 9	2 895				
	the nurse manger t	ave expected follow up from to find this discrepancy. DON f motion is not part of duties.					
	10:55 a.m. the survision should be on the ca	with the DON On 5/29/14 at veyor asked if range of motio are plan. The DON stated, on the care plan because it is	n				
	The DON, director could review and re and procedures reg maintaining proper DON, director of th provide an in-servic providing treatmen care. The DON, dir	THOD FOR CORRECTION: of therapy or designee(s) evise as necessary the policie garding implementing and range of motion care. The erapy or designee(s) could ce for all appropriate staff on t per each resident 's plan of rector of therapy or designee soure residents receive proper- tatment.	f (s)				
	TIME PERIOD FO Twenty-One (21)						
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900				
	comprehensive res of nursing services	sores. Based on the sident assessment, the direct must coordinate the nursing care plan which	or				
	without pressure s pressure sores unle	to enters the nursing home ores does not develop ess the individual's clinical rates, and a physician					

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2 900	Continued From pa	ige 10	2 900				
	authenticates, that	they were unavoidable; and					
	B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.						
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive skin assessment after development of stage one pressure ulcers and failed to develop a comprehensive care plan for skin for 1 of 2 residents (R80) reviewed for pressure ulcers.						
	Findings include:						
	identified admitted failure, deficiency a edema. R80's 14 c dated 1/4/14, identi skin treatment turni and application of c	cord print date of 5/30/14, on 12/6/13, diagnoses of heart nemia, hypertension and day Minimum Data Set (MDS) fied at risk for pressure ulcer, ing and repositioning program dressing to feet, however stage s to both heels had not been					
	12/30/13, at 3:56 a. right heel red, appr and soft, assisted v heel off mattress ar skin/wound note: in both heels red and with Omnifix tape a further skin/wound	of R80's progress notes dated .m., identified skin/wound note oximately 3 cm (centimeters) vith repositioning, elevated nd on 12/30/13, at 3:02 p.m., npaired mobility, pressure, soft, foam placed on bilaterally ind wound nurse notified. No documentation had been	,				
anosota D		otes regarding pressure areas					

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2 900	Continued From pa	age 11	2 900				
	R80's treatment administration sheets dated schedule for 12/2013, 1/14 and 2/14, revealed treatment of cover both heels foam with Omnifix tape until resolved every other day started on 12/30/14 and had last signature for treatment on 2/2/14. However for the month of 1/14, 10 out of 16 days of treatment had no signatures of treatment being completed.						
	predicting pressure assess 12/22/13 at had been complete	of R80' s Braden Scale for e sore risk revealed dates of nd 3/18/14. No assessment ed after development of both heels on 12/30/13.					
	interventions revea 12/11/13, admit cor and discoloration b hospital return corr quarterly review cor skin intact and ider cognitively impaire living, cardiovascul tolerance and lowe Braden assessmen concerns: keep ski each incontinent ep concerns: keep line other risk factors n assessment by lice No assessment ha	skin risk factors and aled dates of completion of mments: skin is intact, bruising out no open areas, 12/22/13, mments: skin is intact, 3/18/14, mments: Braden equals 20, ntified other risk factors d, assist with activities of daily lar disease heart failure, tissue er extremity concerns edema. In tinterventions: moisture in clean and dry, peri care after pisode, friction and sheer en dry and wrinkle free and ot on Braden: weekly skin ensed staff, moisturize dry skin d been completed after essure areas to both heels on	r				
	lying revealed date 12/22/13-12/23/13,	of R80's skin assessment tool of completion , comments: abdomen legs, no redness noted, but					

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	HEPHERD LUTHERA	N HOME 800 HON	IE STREET, B	OX 747		
000 3		RUSHFC	RD, MN 5597	1		
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2 900	Continued From pa	age 12	2 900			
	skin is thin over boney prominence, bruising to both hands/wrists and sitting 12/23/13 comments: sitting tolerance unable relate resident not sitting for allowed time.		:			
	addressed bilateral extremities there had documentation in F interventions to pre- getting worse nor p	re plan print date 5/29/14, had l edema in the lower ad been no other 880's care plan regarding event pressure areas from preventative measures to heal er or prevent others from				
	registered nurse (F documented in pro- both heels of R80 f areas. RN-A stated there had been no nurse regarding pro- RN-A stated the ph and family had not areas on heels. RN- pressure areas on discontinued on 2/4 on both heels had assessments had b development of pro- R80. RN-A verified no skin plan of care ace wraps daily and congestive heart pr looking at the treat the month of 1/201 treatment for both	a 5/29/13, at 8:36 a.m., RN)-A verified red area gress note on 12/30/13, on had been stage one pressure I did not look at heels and documentation by the wound essure areas on R80's heels. hysician or nurse practitioner been notified of the pressure I-A stated the treatment for both heels had been 4/14 when the pressure area resolved. RN-A verified no been completed after the essure ulcers on both heels of R80's current care plan had e other than legs wrapped with d that had been under roblem. RN-A had stated when ment administration record for 4, (10 out of 16 days of heels had no signatures of mpleted) I see what you are				

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GOOD S	HEPHERD LUTHERA		ME STREET, B DRD, MN 5597			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	age 13	2 900			
	of nursing (DON) h ulcer process: case and family should h ulcer develops. DC would be expected wound nurse to sta stated pressure are weekly until resolve expect treatment to on the treatment re DON verified R80's plan of care other t congestive heart fa care plan to have s previous history of GOOD SHEPARD INTEGRITY/PRES SKIN CARE GUID read, "Purpose: To and monitoring pro- ulcer care. To previde development by ide factors and implem preventative interve- To identify and pro- ulcers in an efficient	ad stated facility pressure e manager, dietician, physician be informed when pressure ON had stated case manager to monitor unless open then ep in and monitor. DON had eas should be monitored ed. DON had stated would be completed and signed for ecord as set up to be done. s current care plan had no skin than ace wraps under ailure and would expect R80's skin plan of care due to pressure ulcers on heels. LUTHERAN SERVICES SKIN SURE ULCER PROTOCOL ELINES dated revised 3/28/13 provide a systemic approach beess for skin integrity/pressure	,			
	The DON or desig	THOD OF CORRECTION: nee could educate staff on				
	The DON or design implement policy a	chensive skin assessments. nee could develop and nd procedure regarding				
	pressure ulcers. Au of pressure ulcers	sessments and care of udits of assessments and care could be done routinely to				
		sive assessments and care idents with pressure ulcers.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00123	B. WING		05/30/2014	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
GOOD SI	HEPHERD LUTHERA		IE STREET, B RD, MN 5597			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 14	2 900			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty One				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 4 Tuberculosis ntrol	21426			
	maintain a compre- infection control pro- current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding impleme	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). t include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of e technical assistance ntation of the guidelines. ance with this subdivision must he nursing home.				
	by: Based on interview facility failed to ensist skin test for 1 of 5 for tuberculin skin t Findings include: EE-A personal file results of the first s	ent is not met as evidenced and document review, the sure evidence of tuberculin employees (EE-A) reviewed tests. lacked evidence of reading the step tuberculin skin test and second step tuberculin skin				

1011111630	ta Department of He	ealth						
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
			A. BUILDING: _					
		00123	B. WING		05/	30/2014		
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	SS, CITY, STATE, ZIP CODE				
GOOD S	HEPHERD LUTHERA		ME STREET, B					
		RUSHF	ORD, MN 5597	1		1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
21426	Continued From pa	age 15	21426					
nnesota D	facility New Hire R Document review of form, revealed EE- tuberculin skin test During telephone in a.m., registered nu hire date of 2/10/14 skin test on 2/10/14 shift of resident con During telephone in a.m., RN-B verified personal file lacked step tuberculin skin second step tuber although the facility provide the skin test provided. Document review of Plan policy updated 1. Prior to assumine employees will hav (tuberculosis) unlest positive reaction an Participation in TB condition of employ skin test conversion by Staff Development test results will be a form and filed in th SUGGESTED MET The director of nurse employees respons TB status of new e for giving TB.	nterview on 5/30/14, at 9:14 Irse (RN)-B verified EE-A had 4, received first step tuberculi 4, and verified EE-A's first	n E. Is Is I					
ATE FORI			6899	Y1X11	16	on sheet 16 of		

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00123	B. WING		05/	30/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA		ESTREET, B RD, MN 5597			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21530	MN Rule 4658.1310) A.B.C Drug Regimen Review	21530			
	reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of H Health Care Financ This standard is ind available through th system. It is not su B. The pharma irregularities to the o and the attending p must be acted upor physician visit, or so pharmacist. For pu upon" means the act report and the signi of nursing services C. If the attend with the pharmacist not provide adequa pharmacist believes being adversely affer refer the matter to t if the medical direct physician for the o physician does not must be referred for assessment and as by part 4658.0070. the medical director must refer the matter	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, ing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports to by the time of the next boner, if indicated by the irposes of this part, "acted cceptance or rejection of the ng or initialing by the director and the attending physician. ing physician does not concur 's recommendation, or does te justification, and the s the resident's quality of life is ected, the pharmacist must he medical director for review for is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter r review to the quality surance committee required If the attending physician is or, the consulting pharmacist er directly to the quality surance committee.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00123	B. WING		05/	30/2014
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST	TATE, ZIP CODE		
SOOD S	HEPHERD LUTHERA		ME STREET,B ORD, MN 5597 [.]			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 17	21530			
	by: Based on interview facility failed to ens identified lack of do for as needed (PRI	ent is not met as evidenced and document review, the sure the consultant pharmacist ocumentation of effectiveness N) psychotropic medications (R72) reviewed for cations.	t.			
	Findings include:					
	however; there was determine if the ps effective and the pl	psychotropic medications s not consistent monitoring to ychotropic medication was narmacist had not identified o the physician or the director				
	diagnoses including	to the facility on 4/4/14 with g: dementia with behavioral mer's disease and anxiety sheet.				
	included PRN orde psychotropic medic	cations of " Ativan 0.5 mg uth (PO) - TID [three times a				
	medication adminis R72 received PRN 3/31/14. The facility	ch, April and May 2014 stration record (MAR) showed Ativan 31 times from 3/2/14 to y did not document the PRN Ativan 7 of the 31 times s administered.	D			
		Ativan 40 times from 4/3/14 to facility did not document the	D			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA		IE STREET, B RD, MN 5597			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From page 18 effectiveness of the PRN Ativan 12 of the 40		21530			
		times the medication was administered.				
	5/24/14. Again the	Ativan 5 times from 5/1/14 to facility did not document the PRN Ativan 3 of 5 the times administered.				
	registered nurse (R document the effect psychotropic medic evidenced by the M nursing did not con	on 5/29/14 at 7:40 a.m., N)-A verified nursing was to stiveness of the PRN cation. RN-A verified as IAR and progress notes sistently document the PRN Ativan for R72.				
	and Procedures- un Medications: 1. Wh medications, be su and record of all the (generally on the re a. Date and time m administration and b. Complaint or syn given	inistering Medications policies indated read, "PRN inen administering PRN re to document administration e following information everse side of the MAR): edication, dose, route of if, applicable, the injection site inptoms for which the drug was from giving the dose and time	•			
	results were noted. d. initial or signatur					
	(DON) stated after her expectation wa effectiveness of PR on the MAR or in n click care. The DOI have documentatio effectiveness of the	a.m., the director of nursing a PRN medication was given s for staff to document the RN psychotropic medications urse progress notes in point N verified the facility did not in of follow up for the PRN Ativan for R72 on a				
		tated she would expect this be completed each time a PRN				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER	X/SUPPLIER/CLIA		CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFIC/	ATION NOMBER.	A. BUILDING: _		COM	PLETED
		00123		B. WING		05/	30/2014
NAME OF F	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	HEPHERD LUTHERA	N HOME		ME STREET, B DRD, MN 5597			
(X4) ID PREFIX TAG	SUMMARY ST/ (EACH DEFICIENC REGULATORY OR L		ICIENCIES EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETI DATE
21530	Continued From pa	age 19		21530			
	medication was given to a resident.						
	On 5/29/14 at 11:33 facility was not con for documenting th medications for R7	sistently follow e effectivenes	ving their policy				
	Review of the Consultant Pharmacist Service Agreement (MN) dated 8/1/09 read, "6. Monthly reviews of the drug regimen of each patient with written, dated and signed reports of any irregularities noted will be delivered to the Director of Nurses. The review shall include recommendations regarding aspects of drug administration, interactions, side effects, doses labs and the potential for unnecessary drugs as required by state, federal and other appropriate regulatory groups."						
	During an interview consultant pharma facility to documen psychotropic medic residents.	cist stated he the the the the the the the the the	would expect the ness of PRN	9			
	SUGGESTED MET The director of nur- develop, review, ar procedures to ensu- identifies drug irreg monitoring for effic The director of nur- educate all approp procedures. The director of nur- develop monitoring compliance.	sing (DON) or nd/or revise poure the consul- gularities include acy of medica sing (DON) or riate staff on the sing (DON) or	designee could blicies and tant pharmacist ding appropriate tions. designee could he policies and designee could				
	TIME PERIOD FO (21) Days.	R CORRECTI	ON: Twenty-one	e			

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00123	B. WING		05/	05/30/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
GOOD S	HEPHERD LUTHERA		E STREET,B RD, MN 5597				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21535	Drug Usage; Gener Subpart 1. Genera must be free from u	al. A resident's drug regimen Innecessary drugs. An	21535				
	A. in excessive therapy; B. for excessiv C. without ade D. in the prese which indicate the or discontinued. In addition to the d part 4658.1310, th with provisions in th Code of Federal Re 483.25 (1) found in Operations Manual Long-Term Care Fa Department of Hea Health Care Financ This standard is ind available through th	quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in e nursing home must comply he Interpretive Guidelines for egulations, title 42, section Appendix P of the State , Guidance to Surveyors for acilities, published by the Ith and Human Services, sing Administration, April 1992. corporated by reference. It is he Minitex interlibrary loan te Law Library. It is not					
	This MN Requirem by: Based on interview facility failed to doc needed (PRN) psyc 1 of 5 residents (R7 medications and th gradual dose reduc antipsychotic and a receiving these two provide a physician	ent is not met as evidenced and document review the ument effectiveness for an as chotropic medication used for 72) reviewed for unnecessary e facility failed to attempt a tion and titration of an ntidepressant medication after medications for one year or 's justification why it is his time for 1 of 1 resident (15)					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD SI	HEPHERD LUTHERA		ME STREET,B DRD, MN 5597 [,]			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 21	21535			
	who currently takes Sertraline.	s Abilify (antipsychotic) and				
	however; there was determine if the ps effective and the pl	psychotropic medications s not consistent monitoring to ychotropic medication was harmacist had not identified o the physician or the director				
	diagnoses including	to the facility on 4/4/14 with g: dementia with behavioral imer's disease and anxiety sheet.				
	included PRN orde psychotropic medic	cations of "Ativan 0.5 mg uth (PO) - TID [three times a				
	medication adminis R72 received PRN 3/31/14. The facility	ch, April and May 2014 stration record (MAR) showed Ativan 31 times from 3/2/14 to y did not document the PRN Ativan 7 of the 31 times s administered.				
	4/30/14. Again the effectiveness of the	Ativan 40 times from 4/3/14 to facility did not document the PRN Ativan 12 of the 40 on was administered.				
	5/24/14. Again the	Ativan 5 times from 5/1/14 to facility did not document the PRN Ativan 3 of 5 the times administered.				
	During an interview	/ on 5/29/14 at 7:40 a.m.,				

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00123	B. WING	B. WING		30/2014
IAME OF F	ROVIDER OR SUPPLIER		ADDRESS, CITY, S	TATE, ZIP CODE		
	HEPHERD LUTHERA		ME STREET, B			
		RUSHF	ORD, MN 5597			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 22	21535			
	document the effect psychotropic medic evidenced by the M nursing did not com effectiveness of the Review of the Adm and Procedures- un Medications: 1. Wh medications, be su and record of all th (generally on the re a. Date and time m administration and b. Complaint or syr given	ten administering PRN re to document administration e following information everse side of the MAR): redication, dose, route of if, applicable, the injection sit nptoms for which the drug wa	n e. as			
	On 5/29/14 at 9:52 a.m., the director of nursing (DON) stated after a PRN medication was given her expectation was for staff to document the effectiveness of PRN psychotropic medications on the MAR or in nurse progress notes in point click care. The DON verified the facility did not have documentation of follow up for the effectiveness of the PRN Ativan for R72 on a consistent basis. Stated she would expect this documentation to be completed each time a PRN medication was given to a resident.		N			
	medications for R7 R15 received daily	e effectiveness of PRN 2. dose of an antipsychotic antidepressant for the past				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00123	B. WING	B. WING		05/30/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•		
GOOD S	HEPHERD LUTHER		ME STREET, B DRD, MN 5597				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21535	Continued From pa	age 23	21535				
	medication titration physician 's justified	I dose reduction (GDR) or a n had been attempted or had a cation as to why the GDR and aindicated at this time					
	in bed in room doin able to respond to just taking an after	5 p.m., R15 was observed lying ng a puzzle. R15 was alert and questions and stated she was moon rest. R15 initiated stated she is battling a cold and	t l				
	lying in bed and sta	n., R15 was observed in room ated she just woke up but was p as she usually sleeps until					
	degenerative joint morbid obesity, hy disease, Factor V	om 3/12/14 lists diagnoses of: disease, cva (stroke), hip pain pertension, chronic kidney Leiden deficiency (blood , depression, and renal cyst.	,				
	indicates monitorir	or Monitoring Book on 5/29/14 ng for depression symptoms is terventions are listed.					
	orders for Abilify (a	der sheet for May 2014 has antipsychotic) 5 mg per day and ressant) 150 mg every day.	b				
	Pharmacist on 4/2 reduction for Abilify Dosing and Gradu document rational reduction. The for but documentation	as made by the Consultant 3/14 recommending a dose y or use of the Antipsychotic al Reduction Form to e for not attempting a dose m was completed on 5/6/14, did not comply with the delines listed in the pharmacy					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00123	B. WING		05/	5/30/2014	
IAME OF F	PROVIDER OR SUPPLIER	STREE	ADDRESS, CITY, ST	ATE, ZIP CODE	• • • • •		
GOOD S	HEPHERD LUTHERA		OME STREET, B FORD, MN 55971				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21535	Continued From pa	age 24	21535				
	Gradual Reduction 11/14/12 and 5/6/14 been attempted. T Medication Quarter that a gradual dose medications should	ress note. The Antidepressa Form was completed on 4 but dosage reduction has in the facility's Antipsychotic rly Evaluation form indicates a reduction of psychoactive be attempted after the on an antipsychotic not more	not				
	director of nursing and procedure for r medications and do quantative charting managers and stat	v on 5/29/14 at 9:15 a.m., (DON) was asked for policy monitoring psychoactive ose reduction. DON stated is done by the nurse ed there is no policy for cations and dose reduction.					
	The director of nurs	THOD OF CORRECTION: sing or pharmacist could esponsible for medication us et the requirements as writte g order.					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty O	ne				
21665	MN Rule 4658.140	0 Physical Environment	21665				
	functional, comforta environment, allow	ust provide a safe, clean, able, and homelike physical ing the resident to use is to the extent possible.					
	by: Based on observat	ent is not met as evidenced ion, interview, and documen ailed to ensure 5 of 10					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00123	B. WING		05/	30/2014
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•	
	HEPHERD LUTHERA		ME STREET, B DRD, MN 5597			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	Continued From page 25				
		resident (R49, R26, R54, R15, R16) wheelchairs were in a state of good repair.				
	Findings include:					
	maintenance (M)-A for the nursing dep Maintenance Work maintenance depai problem with safety needed. M-A state maintenance staff maintenance made notified. During in maintenance-B and had no wheelchair During interview or licensed social wor had no policy for m repairs. LSW-A sta practice was to not	in the facility. M-A stated e repairs as soon as they were terview at that time, d Maintenance-C verified they				
		rm rests and back of chair had n was rough to the touch not a	ł			
	R49 sat in a lounge wheelchair beside time, revealed the	s on 5/28/14, at 1:30 p.m., e chair in the facility lobby with the chair. Observations at tha wheelchair right arm rest had ng vinyl with cloth exposed.	t			
	R49 received morn the foot of the bed.	s on 5/29/14, at 7:25 a.m., as ing cares, wheelchair sat at Observations at that time rest of wheelchair cracked and				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00123			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING		05/	05/30/2014		
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
	HEPHERD LUTHERA	N HOME 800 HON	IE STREET, B	OX 747			
1000 3		RUSHFC	RD, MN 5597	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIV TAG CROSS-REFERENCE		N OF CORRECTION (X5) ACTION SHOULD BE COMPLE TO THE APPROPRIATE DATE IENCY)		
21665	Continued From page 26		21665				
	wheelchair with sm large area of back come in contact wi missing with cloth of that time, R49 state medical appointme stated he " really w him another wheel scratched his arms During interview or licensed practical r	cloth exposed, left arm rest of nall area of cracked vinyl, and of wheelchair which would th resident, vinyl cracked and exposed. During interview at ed he took the wheelchair to ents three times a week. R49 vished " the facility would find chair. R49 stated he had s on the rough vinyl. n 5/29/14, at 8:05 a.m., nurse (LPN)-A verified the exposed cloth on both					
	LPN-A stated the favinyl. During obserup both arms to rev R26 was identified	acility needed to replace the rvations at that time, R49 held veal no scratches at present.					
	have moderate cog mobility device of v	n assessment dated 3/11/14, to gnitive impairment, used vheelchair and walker, and assistance of 1 staff for off unit.					
	dated 2/17/14, dire	of facility resident care plan cted staff R26, was able to stance but required staff to ns.					
	R26 was in bed wit Observations at the wheelchair outer le and upper back of in contact with resi- vinyl with cloth exp	is on 5/29/14, at 10:00 a.m., ih wheelchair by the bedside. at time revealed R26 ' s ift arm rest had cracked vinyl wheelchair which would come dent had cracked and missing osed. During interview at that he cracked vinyl had not					

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00123					(X3) DATE SURVEY COMPLETED	
		B. WING		05/	05/30/2014	
			ADDRESS, CITY, ST	DDRESS, CITY, STATE, ZIP CODE		
	HEPHERD LUTHERA		ME STREET, B			
	SI IMMA DV ST		ORD, MN 5597	PROVIDER'S PLAN OF		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From page 27		21665			
	During interview on 5/29/14, at 10:00 a.m., registered nurse (RN)-C stated cracked vinyl on wheelchairs should be reported to maintenance for repairs. RN-C stated she was not aware of cracked vinyl on R26's wheelchair. RN-C stated there had been no injury to R26 from the cracked vinyl.					
	was sitting in whee wheelchair had cra missing. Licensed interviewed at 1:40 not aware of the wh that housekeeping	on 5/29/14, at 1:00 p.m., R54 lichair in hallway. R54's licks and pieces of vinyl Practical Nurse (LPN)-A was p.m., and stated that she was heelchair arm issue and stated is responsible for cleaning the sing and housekeeping can aintenance.	s d			
	2/12/14, indicated t long distances and	of R54's care plan dated that R54 uses a wheelchair for requires assistance of 1 staff s diagnoses of Dementia and v impairment.				
	wheelchair in room and pieces of vinyl the arm rest does s or alterations in ski p.m., Registered N and stated she was issue and stated th	on 5/29/14, R15 was sitting in Left armrest was cracked were missing. R15 stated that scratch her arm. No scratches in noted at that time. At 1:00 urse (RN)-C was interviewed s unaware of the wheelchair hat staff is supposed to alert the they can notify maintenance.	at S			
	4/11/14, identifies a daily living). Intervention: I would	of R 15's care plan, dated a deficit in ADL's (activities of entions included: "Skin d like my SKIN inspected daily ss, open areas, scratches,				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00123		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00123	B. WING		05/30/2014		
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, S				
OOD SH	HEPHERD LUTHERA		NE STREET,B DRD, MN 5597 [°]				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	UST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU		TION SHOULD BE THE APPROPRIATE	JLD BE COMPLE	
21665	Continued From page 28		21665				
	cuts, bruises and report changes to the Nurse." The care plan does not address wheelchair mobility but does indicate R15 needs assistance of 2 staff and the mechanical lift for all transfers due to stroke and obesity.						
	R16 was observed on 5/29/14, at 9:00 a.m., R16 was sitting in wheelchair in hallway. R16's wheelchair arms had cracks and pieces of vinyl missing. R16 stated it had to be replaced and stated that it does hurt his arm. Skin on R16's arms intact at that time. Licensed Social Worker, (LSW)-A was present during observation and stated she would report it to maintenance and verified that the wheelchair arms did need repair.						
	5/2/2014, indicated alteration in skin in directed staff to mo redness or irritation needed. Care plan Coumadin (blood th included, "Cares an observed for any a of mobility; indepen	of R16's care plan dated I that R16 has the potential for tegrity and interventions onitor skin condition, report any n and apply moisturizer as n also addresses use of hinner) and interventions re done gently and skin is Iteration. I have a higher level indent with wheelchair my activity also puts me at sing."	,				
	The maintenance of visual inspection of	THOD OF CORRECTION: department could include a f residents wheelchairs house eelchairs were in good repair					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty One					