DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0Y1X

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00123

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245393**

2.STATE VENDOR OR MEDICAID NO.
(L2) **308740900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SHEPHERD LUTHERAN HOME**
(L4) **800 HOME STREET, BOX 747**
(L5) **RUSHFORD, MN** (L6) **55971**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **7/23/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **75** (L18)

13.Total Certified Beds **75** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gail Sorensen, HFE NE II 06/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/27/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/29/14 Co.
RePosted 08/08/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/27/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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,

Kamala 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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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,

Kamala 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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245393	A. Building B. Wing	7/23/2014

Name 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	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **06/24/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **06/24/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **06/24/2014**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **06/24/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/24/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **06/24/2014**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **06/24/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KFD	07/29/2014	19694	07/23/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/30/2014			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245393	01 - MAIN BUILDING 01	6/25/2014

Name 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0062	06/12/2014	ID Prefix Reg. # NFPA 101 LSC K0144	06/12/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/kfd	Date: 07/29/2014	Signature of Surveyor: 25822	Date: 06/25/22014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/27/2014			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00123	A. Building B. Wing	7/23/2014

Name 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 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** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **06/24/2014**	ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **06/24/2014**	ID Prefix **20895** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **06/24/2014**
ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **06/24/2014**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Su** LSC	Correction Completed **06/24/2014**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **06/24/2014**
ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	Correction Completed **06/24/2014**	ID Prefix **21665** Reg. # **MN Rule 4658.1400** LSC	Correction Completed **06/24/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KFD	07/29/2014	19694	07/23/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/30/2014				

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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,

Kamala 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0Y1X

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00123

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245393**

2.STATE VENDOR OR MEDICAID NO.
(L2) **308740900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SHEPHERD LUTHERAN HOME**
(L4) **800 HOME STREET, BOX 747**
(L5) **RUSHFORD, MN** (L6) **55971**

4. TYPE OF ACTION: **2** (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/30/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **75** (L18)

13.Total Certified Beds **75** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 06/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/27/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
____

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 06/27/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

Remedies - 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;

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

Informal Dispute Resolution - 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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING _____ B. WING _____ JUN 20 2014 MN Dept of Health Rochester	05/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (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. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	See Attachment #1 6/20/14 SPM	6/20/14 SPM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas C Kindt | TITLE: Administrator | (X6) DATE: 6/22/2014

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	Completion Date
F 279	**Corrective Action:** MN Dept of Health Rochester 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. **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.	5/31/14 6/20/14

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	245393	A. BUILDING _____ B. WING _____	05/30/2014

JUN 20 2014
MN Dept of Health
Rochester

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GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

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F 279	Continued From page 1 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: R34 had been admitted on 5/20/10. R34's admission record dated 5/29/14, identified diagnoses of chronic airway obstruction, congestive heart failure and hypertension. R34's physician orders dated 5/27/14, revealed orders for Advair (contains fluticasone a steroid and salmeterol a bronchodilator that works by relaxing muscles in the airways to improve breathing) 500/50 one puff by inhalation twice daily for chronic airway obstruction, DuoNeb (a sterile inhalation solution containing a combination of albuterol and ipratropium that are bronchodilators that relax muscles in the airways and increase air flow to the lungs) 2.5 mg (milligrams)/3 ml (milliliter) one vial by inhalation four times daily and every four hours as needed for chronic airway obstruction, losartan (a medication used to treat high blood pressure) 12.5 mg by mouth every day for hypertension and metoprolol XL (extended release) (a medication used to treat high blood pressure) 50 mg by mouth every day for hypertension. Document review of R34's medication administration record dated schedule for 5/14, revealed R34 had received Advair 500/50 one puff by inhalation twice daily, DuoNeb 2.5 mg/3	F 279		

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F 279	Continued From page 2 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. R34's care plan print date 5/29/14, had not addressed chronic airway obstruction or hypertension. During interview on 5/29/14, at 1:29 p.m., registered nurse (RN)-C had stated R34's care plan does not address chronic airway obstruction or hypertension. During interview on 5/29/14, at 1:36 p.m., RN-B had stated hypertension and chronic airway obstruction should probably be care planned if R34 is getting medications for the diagnoses. Document review of the facility GOOD SHEPARD LUTHERAN HOME POLICIES AND PROCEDURES NURSING CARE PLAN dated revised 11/15/12, read, "1. Assessment Each resident will be evaluated upon admission in the following areas: d. Medical problems - what problems are related to each diagnosis, medication and/or treatment. 2. Care Plan b. Problem/Needs A problem is defined as any significant deviation that has influenced, is now influencing, or may influence the resident ' s state of health or his/her ability to function normally. A need is defined as a condition requiring supply or relief... "	F 279		6/24/14
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280		6/20/14 spn

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F 280	Continued From page 3 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 1 of 1 resident (R6) with contractures. Findings include: On 5/28/14 at 1:55 p.m., R6 was observed sitting in wheelchair in community area. R6 was unable to open right hand when asked. The fingers on R6' right hand was flexed into hand but fingers were moveable. R6 can move left hand/arm. R6 denied having pain when asked, shook head and pointed to right hand. R6 is unable to respond verbally to questions but does attempt to respond non-verbally by using left hand, head and vocal sounds. Surveyor observed R6 working with Clinical Manager, (CM)-A. R6 could not open right hand, could not straighten wrist and	F 280	See Attachment #2	

Tag	Good Shepherd Lutheran Home Plan of Corrections Attachment number 2	Correction Date
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. **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. Each resident's care plan will be updated specifically addressing their current needs re: contractures after evaluation. **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. **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.	6/17/14 6/20/14 7/8/14 6/24/14

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MN Dept of Health Rochester

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F 280	Continued From page 4 displayed facial grimacing of pain. The Physician Evaluation document dated 4/29/14, lists current diagnoses of: right hemiparesis (paralysis), speechless, and expressive aphasia (language disturbance). The physician's order sheet signed on 4/19/14, gives orders for passive range of motion to right upper and both lower extremities 3 times a day, nights to incorporate range of motion during toileting and repositioning, every shift. Order start date was 9/24/10. R6's care plan did not address range of motion as ordered by the physician. Care plan dated 3/5/14 read, "I have occ [occasional] pain r/t [due to] muscles spasms/contractures." Also "I have limited physical mobility r/t right body paresis, contractures. Provide gentle range of motion as tolerated with daily care." During an interview with the director of nursing on 5/29/14 at 10:55 a.m. DON stated, "Yes, it should be on the care plan because it is a physician's order."	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	See Attachment #3	6/24/14 6/20/14 upn

Tag	Good Shepherd Lutheran Home Plan of Corrections Attachment number 3	Completion Date
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. **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 re-educated on identification and notifications required when a pressure ulcer is identified as well as the required documentation. Floor Nurses were re-educated 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	6/18/14 6/20/14 6/24/14

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GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

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F 314	Continued From page 5 This 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: R80's admission record print date of 5/30/14, identified admitted on 12/6/13, diagnoses of heart failure, deficiency anemia, hypertension and edema. R80's 14 day Minimum Data Set (MDS) dated 1/4/14, identified at risk for pressure ulcer, skin treatment turning and repositioning program and application of dressing to feet, however stage one pressure ulcers to both heels had not been documented. Document review of R80's progress notes dated 12/30/13, at 3:56 a.m., identified skin/wound note: right heel red, approximately 3 cm (centimeters) and soft, assisted with repositioning, elevated heel off mattress and on 12/30/13, at 3:02 p.m., skin/wound note: impaired mobility, pressure, both heels red and soft, foam placed on bilaterally with Omnifix tape and wound nurse notified. No further skin/wound documentation had been noted in progress notes regarding pressure areas both heels after 12/30/13. 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	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING _____ B. WING _____ JUN 20 2014 MN Dept of Health Review Team	05/30/2014

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GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

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F 314	Continued From page 6 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. Document review of R80' s Braden Scale for predicting pressure sore risk revealed dates of assess 12/22/13 and 3/18/14. No assessment had been completed after development of pressure areas to both heels on 12/30/13. R80's checklist for skin risk factors and interventions revealed dates of completion of 12/11/13, admit comments: skin is intact, bruising and discoloration but no open areas, 12/22/13, hospital return comments: skin is intact, 3/18/14, quarterly review comments: Braden equals 20, skin intact and identified other risk factors cognitively impaired, assist with activities of daily living, cardiovascular disease heart failure, tissue tolerance and lower extremity concerns edema. Braden assessment interventions: moisture concerns: keep skin clean and dry, peri care after each incontinent episode, friction and sheer concerns: keep linen dry and wrinkle free and other risk factors not on Braden: weekly skin assessment by licensed staff, moisturize dry skin. No assessment had been completed after development of pressure areas to both heels on 12/30/13. Document review of R80's skin assessment tool lying revealed date of completion 12/22/13-12/23/13, comments: abdomen bruising, edema to legs, no redness noted, but 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.	F 314		

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F 314	Continued From page 7 Although R80's care plan print date 5/29/14, had addressed bilateral edema in the lower extremities there had been no other documentation in R80's care plan regarding interventions to prevent pressure areas from getting worse nor preventative measures to heal current stage I ulcer or prevent others from occurring. During interview on 5/29/13, at 8:36 a.m., registered nurse (RN)-A verified red area documented in progress note on 12/30/13, on both heels of R80 had been stage one pressure areas. RN-A stated I did not look at heels and there had been no documentation by the wound nurse regarding pressure areas on R80's heels. RN-A stated the physician or nurse practitioner and family had not been notified of the pressure areas on heels. RN-A stated the treatment for pressure areas on both heels had been discontinued on 2/4/14 when the pressure area on both heels had resolved. RN-A verified no assessments had been completed after the development of pressure ulcers on both heels of R80. RN-A verified R80's current care plan had no skin plan of care other than legs wrapped with ace wraps daily and that had been under congestive heart problem. RN-A had stated when looking at the treatment administration record for the month of 1/2014, (10 out of 16 days of treatment for both heels had no signatures of treatment being completed) I see what you are seeing RN-A said to the surveyor. During interview on 5/29/14, at 9:37 a.m., director of nursing (DON) had stated facility pressure ulcer process: case manager, dietician, physician and family should be informed when pressure	F 314		

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F 314	Continued From page 8 ulcer develops. DON had stated case manager would be expected to monitor unless open then wound nurse to step in and monitor. DON had stated pressure areas should be monitored weekly until resolved. DON had stated would expect treatment to be completed and signed for on the treatment record as set up to be done. DON verified R80's current care plan had no skin plan of care other than ace wraps under congestive heart failure and would expect R80's care plan to have skin plan of care due to previous history of pressure ulcers on heels. GOOD SHEPARD LUTHERAN SERVICES SKIN INTEGRITY/PRESSURE ULCER PROTOCOL SKIN CARE GUIDELINES dated revised 3/28/13, read, "Purpose: To provide a systemic approach and monitoring process for skin integrity/pressure ulcer care. To prevent pressure ulcer development by identifying each resident's risk factors and implementing appropriate preventative interventions for those risk factors. To identify and promote healing of pressure ulcers in an efficient and timely manner and prevent the development of additional pressure ulcers ... "	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318	See Attachment #4	6/24/14 MM

Tag	Good Shepherd Lutheran Home Plan of Corrections Attachment number 4 JUN 20 2014	Completion Date
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. **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. **Responsible Person:** Household Managers and Case Managers monitored by Director of Nursing.	6/17/14 6/20/14 6/24/14 SPM

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion services as ordered by the physician and failed to assess the resident's need for range of motion and failed to revise the plan of care for 1 of 1 resident (R6) with contractures. Findings include: R6 was observed on 5/28/14 at 1:55 p.m., R6 and was sitting in wheelchair in the community area. R6 was unable to open right hand when asked. The fingers on R6' right hand was flexed into hand but fingers were moveable. R6 can move left hand/arm. R6 denied having pain when asked, shook head and pointed to right hand. R6 is unable to respond verbally to questions but does attempt to respond non-verbally by using left hand, head and vocal sounds. Surveyor observed R6 working with Clinical Manager (CM)-A and again R6 could not open right hand, could not straighten wrist and also displayed facial grimacing of discomfort. The Physician Evaluation document dated 4/29/14, lists current diagnoses of: right hemiparesis (paralysis), speechless, and expressive aphasia (language disturbance). The physician's order sheet signed on 4/19/14, gives orders for passive range of motion to right upper and both lower extremities TID (3 times a day), nights to incorporate range of motion during toileting and repositioning, q shift (every shift). Order start date was 9/24/10. R6's current comprehensive care plan did not	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING _____ B. WING _____ JUN 20 2014	05/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971 MN Dept of Health Rochester

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F 318	Continued From page 10 address range of motion services as ordered by the physician. Care plan dated 3/5/14 reads: "I have occ [occasional] pain r/t [due to] muscles spasms/contractures." also "I have limited physical mobility r/t right body paresis, contractures." And "Provide gentle range of motion as tolerated with daily care." POC (Point of Care) directions for nursing assistants (NA) included: passive range of motion exercises to right upper and both lower extremities, apply hamstring and heel cord stretches to both. QD (every day). During an interview on 5/28/14 at 2:00 p.m., NA-B stated that nursing does range of motion on the right side by stretching and moving fingers and also does range of motion to right leg daily. Stated it is done for 15 minutes and R6 tolerates it fair, has some discomfort but not pain. NA-B also stated if R6 did have pain during range of motion the resident would report it. NA-B stated R6 is not usually medicated before therapy and also stated that she has not seen a change in R6's hand for 3 years. During an interview with RN-A on 5/28/14 at 2:24 p.m., the surveyor gave RN-A the current signed physician's orders for range of motion tid (3 times per day) and restorative nursing orders for daily and asked which was correct. RN-A stated, "Restorative orders should have been deleted, I must have forgotten to take it out " On 5/29/14 at 10:33 a.m., the trained medication assistant (TMA)-A who is the household manager stated that she communicates with RN-A, unit manager, regarding changes or concerns. When asked how R6 tolerates range of motion	F 318		

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F 318	Continued From page 11 exercises TMA-A stated, "Not very well, she does have some discomfort. If she does, range of motion is stopped." Stated that the night shift does "gentle, relaxing range of motion." When asked by surveyor to clarify what that meant, TMA-A stated, "It is in the care plan." When asked if the nursing assistants have directions anywhere for what to do specifically for this resident for range of motion, TMA-A said, "No, everyone knows the residents pretty well. " During an interview with the Director of Nursing (DON) on 5/29/14 at 10:45 a.m., DON stated, R6 doesn't like range of motion so it is incorporated into her cares. When asked how often this was done, stated she wasn ' t sure. When asked what type of range of motion is done, she said," ankle." DON was asked if she was aware that orders for both restorative nursing and range of motion are still on the current physician order sheet and it is ordered to be done 3 times per day, and according to nursing assistant documentation range of motion is only being done daily or 2 times a day. The DON stated she would have expected follow up from the nurse manger to find this discrepancy. DON stated that range of motion is not part of restorative nursing duties. During an interview with the DON On 5/29/14 at 10:55 a.m. the surveyor asked if range of motion should be on the care plan. The DON stated, "Yes, it should be on the care plan because it is a physician order."	F 318		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		

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	245393	A. BUILDING _____ B. WING _____ JUN 20 2014 MN Dept of Health Region	05/30/2014

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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. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to document effectiveness for an as needed (PRN) psychotropic medication used for 1 of 5 residents (R72) reviewed for unnecessary medications and the facility failed to attempt a gradual dose reduction and titration of an antipsychotic and antidepressant medication after receiving these two medications for one year or provide a physician's justification why it is contraindicated at this time for 1 of 1 resident (15) who currently takes Abilify (antipsychotic) and Sertraline.	F 329	See Attachment # 5	6/24/14

Tag	Good Shepherd Lutheran Services Plan of Corrections Attachment number 5	Completion Date
F 329	**Corrective Action:** 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.	6/19/14
	R15 was seen by the NP on 6/17/14 for review of her medications including 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.	6/17/14
	Identification: All nurses have the potential of failing to chart results achieved from giving a 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.	6/24/14
	All residents with current orders for an antipsychotic medication have had their medication reviewed to ensure a gradual dose reduction were performed per regulations unless found to be clinically contraindicated.	6/20/14
	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.	

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F 329	Continued From page 13 Findings include: R72 received PRN psychotropic medications however; there was not consistent monitoring to determine if the psychotropic medication was effective and the pharmacist had not identified and reported this to the physician or the director of nursing. R72 was admitted to the facility on 4/4/14 with diagnoses including: dementia with behavioral disturbance, Alzheimer's disease and anxiety state per the face sheet. R72's current physician orders dated 4/24/14 included PRN orders for the following psychotropic medications of "Ativan 0.5 mg [milligrams] by mouth (PO) - TID [three times a day] PRN [as needed]." Review of the March, April and May 2014 medication administration record (MAR) showed R72 received PRN Ativan 31 times from 3/2/14 to 3/31/14. The facility did not document the effectiveness of the PRN Ativan 7 of the 31 times the medication was administered. R72 received PRN Ativan 40 times from 4/3/14 to 4/30/14. Again the facility did not document the effectiveness of the PRN Ativan 12 of the 40 times the medication was administered. R72 received PRN Ativan 5 times from 5/1/14 to 5/24/14. Again the facility did not document the effectiveness of the PRN Ativan 3 of 5 the times the medication was administered. During an interview on 5/29/14 at 7:40 a.m., registered nurse (RN)-A verified nursing was to	F 329		

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F 329	Continued From page 14 document the effectiveness of the PRN psychotropic medication. RN-A verified as evidenced by the MAR and progress notes nursing did not consistently document the effectiveness of the PRN Ativan for R72. Review of the Administering Medications policies and Procedures- undated read, "PRN Medications: 1. When administering 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 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. 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 for R72. R15 received daily dose of an antipsychotic medication and an antidepressant for the past year and a gradual dose reduction (GDR) or a	F 329		

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F 329	Continued From page 15 medication titration had been attempted or had a physician ' s justification as to why the GDR and titration was contraindicated at this time completed. On 5/28/14 at 2:45 p.m., R15 was observed lying in bed in room doing a puzzle. R15 was alert and able to respond to questions and stated she was just taking an afternoon rest. R15 initiated conversation and stated she is battling a cold and sore throat. 5/29/14 at 7:40 a.m., R15 was observed in room lying in bed and stated she just woke up but was going back to sleep as she usually sleeps until 10:00 a.m. Physician notes from 3/12/14 lists diagnoses of: degenerative joint disease, cva (stroke), hip pain, morbid obesity, hypertension, chronic kidney disease, Factor V Leiden deficiency (blood condition), anemia, depression, and renal cyst. Review of Behavior Monitoring Book on 5/29/14 indicates monitoring for depression symptoms is being done and interventions are listed. R15's physician order sheet for May 2014 has orders for Abilify (antipsychotic) 5 mg per day and Sertraline (antidepressant) 150 mg every day. A progress note was made by the Consultant Pharmacist on 4/23/14 recommending a dose reduction for Abilify or use of the Antipsychotic Dosing and Gradual Reduction Form to document rationale for not attempting a dose reduction. The form was completed on 5/6/14, but documentation did not comply with the recommended guidelines listed in the pharmacy	F 329		

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F 329	Continued From page 16 consultant ' s progress note. The Antidepressant Gradual Reduction Form was completed on 11/14/12 and 5/6/14 but dosage reduction has not been attempted. The facility's Antipsychotic Medication Quarterly Evaluation form indicates that a gradual dose reduction of psychoactive medications should be attempted after the resident has been on an antipsychotic not more than 6 months. During an interview on 5/29/14 at 9:15 a.m., director of nursing (DON) was asked for policy and procedure for monitoring psychoactive medications and dose reduction. DON stated quantative charting is done by the nurse managers and stated there is no policy for psychoactive medications and dose reduction.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist identified lack of documentation of effectiveness for as needed (PRN) psychotropic medications	F 428	See attachment #26	6/24/14 SPN

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. **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. **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. **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	6/19/14 6/20/14 6/24/14 SPM

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F 428	Continued From page 17 for 1 of 5 residents (R72) reviewed for unnecessary medications. Findings include: R72 received PRN psychotropic medications however; there was not consistent monitoring to determine if the psychotropic medication was effective and the pharmacist had not identified and reported this to the physician or the director of nursing. R72 was admitted to the facility on 4/4/14 with diagnoses including: dementia with behavioral disturbance, Alzheimer's disease and anxiety state per the face sheet. R72's current physician orders dated 4/24/14 included PRN orders for the following psychotropic medications of " Ativan 0.5 mg [milligrams] by mouth (PO) - TID [three times a day] PRN [as needed]." Review of the March, April and May 2014 medication administration record (MAR) showed R72 received PRN Ativan 31 times from 3/2/14 to 3/31/14. The facility did not document the effectiveness of the PRN Ativan 7 of the 31 times the medication was administered. R72 received PRN Ativan 40 times from 4/3/14 to 4/30/14. Again the facility did not document the effectiveness of the PRN Ativan 12 of the 40 times the medication was administered. R72 received PRN Ativan 5 times from 5/1/14 to 5/24/14. Again the facility did not document the effectiveness of the PRN Ativan 3 of 5 the times the medication was administered.	F 428		

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F 428	Continued From page 18 During an interview on 5/29/14 at 7:40 a.m., registered nurse (RN)-A verified nursing was to document the effectiveness of the PRN psychotropic medication. RN-A verified as evidenced by the MAR and progress notes nursing did not consistently document the effectiveness of the PRN Ativan for R72. Review of the Administering Medications policies and Procedures- undated read, "PRN Medications: 1. When administering 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 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. 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 for R72.	F 428		

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F 428	Continued From page 19 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 on 5/29/14 at 12:48 p.m. the consultant pharmacist stated he would expect the facility to document the effectiveness of PRN psychotropic medications administered to residents.	F 428		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 5 of 10 resident (R49, R26, R54, R15, R16) wheelchairs were in a state of good repair. Findings include: During interview on 5/29/14, at 10:05 a.m., maintenance (M)-A stated the facility system was	F 465	See Attachment #7	6/24/14 SPM

Tag	Good Shepherd Lutheran Home Plan of Corrections Attachment number 7	Completion Date
F 465	**Corrective Action:** R49, R26, R54, R15 and R16 all received a different wheelchair free of all defects in the vinyl surfaces. **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. **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 in-service on 6/24/14 to immediately report any wheelchair defects to the maintenance department for prompt repair between washings. **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.	JUN 20 2014 MN Dept of Health Roches... 6/20/14 6/24/14 RPN

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F 465	Continued From page 20 for the nursing department to complete a " Maintenance Work Request" a pink slip to notify maintenance department when there was a problem with safety concerns or repairs were needed. M-A stated there were three maintenance staff in the facility. M-A stated maintenance made repairs as soon as they were notified. During interview at that time, maintenance-B and Maintenance-C verified they had no wheelchair repair requests. During interview on 5/29/14, at 1:08 p.m., licensed social worker (LSW)-A stated the facility had no policy for maintenance notification for repairs. LSW-A stated facility standard of practice was to notify maintenance when repairs were needed, by completing a maintenance work order slip. R49's wheelchair arm rests and back of chair had cracked vinyl which was rough to the touch not a cleanable surface. During observations on 5/28/14, at 1:30 p.m., R49 sat in a lounge chair in the facility lobby with wheelchair beside the chair. Observations at that time, revealed the wheelchair right arm rest had cracked and missing vinyl with cloth exposed. During observations on 5/29/14, at 7:25 a.m., as R49 received morning cares, wheelchair sat at the foot of the bed. Observations at that time revealed right arm rest of wheelchair cracked and missing vinyl with cloth exposed, left arm rest of wheelchair with small area of cracked vinyl, and large area of back of wheelchair which would come in contact with resident, vinyl cracked and missing with cloth exposed. During interview at that time, R49 stated he took the wheelchair to	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING _____ B. WING _____ JUN 20 2014 MN Dept of Health	05/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 21 medical appointments three times a week. R49 stated he " really wished " the facility would find him another wheelchair. R49 stated he had scratched his arms on the rough vinyl. During interview on 5/29/14, at 8:05 a.m., licensed practical nurse (LPN)-A verified the cracked vinyl and exposed cloth on both wheelchair arm rests and back of wheelchair. LPN-A stated the facility needed to replace the vinyl. During observations at that time, R49 held up both arms to reveal no scratches at present. R26 was identified on the quarterly Minimum Data Set (MDS), an assessment dated 3/11/14, to have moderate cognitive impairment, used mobility device of wheelchair and walker, and required extensive assistance of 1 staff for locomotion on and off unit. Document review of facility resident care plan dated 2/17/14, directed staff R26, was able to wheel self-short distance but required staff to wheel to destinations. During observations on 5/29/14, at 10:00 a.m., R26 was in bed with wheelchair by the bedside. Observations at that time revealed R26 ' s wheelchair outer left arm rest had cracked vinyl and upper back of wheelchair which would come in contact with resident had cracked and missing vinyl with cloth exposed. During interview at that time, R26 stated the cracked vinyl had not scratched her arms. 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	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING _____ B. WING _____	05/30/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 22 cracked vinyl on R26's wheelchair. RN-C stated there had been no injury to R26 from the cracked vinyl. R54 was observed on 5/29/14, at 1:00 p.m., R54 was sitting in wheelchair in hallway. R54's wheelchair had cracks and pieces of vinyl missing. Licensed Practical Nurse (LPN)-A was interviewed at 1:40 p.m., and stated that she was not aware of the wheelchair arm issue and stated that housekeeping is responsible for cleaning the chair and both nursing and housekeeping can report issues to maintenance. Document review of R54's care plan dated 2/12/14, indicated that R54 uses a wheelchair for long distances and requires assistance of 1 staff. Care plan identifies diagnoses of Dementia and short term memory impairment. R15 was observed on 5/29/14, R15 was sitting in wheelchair in room. Left armrest was cracked and pieces of vinyl were missing. R15 stated that the arm rest does scratch her arm. No scratches or alterations in skin noted at that time. At 1:00 p.m., Registered Nurse (RN)-C was interviewed and stated she was unaware of the wheelchair issue and stated that staff is supposed to alert the Nurse Manager so they can notify maintenance. Document review of R 15's care plan, dated 4/11/14, identifies a deficit in ADL's (activities of daily living). Interventions included: "Skin Inspection: I would like my SKIN inspected daily. Observe for redness, open areas, scratches, 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.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING _____ B. WING _____ JUN 20 2014	05/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

MN Dept of Health
Rochester

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 23 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. Document review of R16's care plan dated 5/2/2014, indicated that R16 has the potential for alteration in skin integrity and interventions directed staff to monitor skin condition, report any redness or irritation and apply moisturizer as needed. Care plan also addresses use of Coumadin (blood thinner) and interventions included, "Cares are done gently and skin is observed for any alteration. I have a higher level of mobility; independent with wheelchair mobility/walking so my activity also puts me at higher risk for bruising."	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	05/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	**800 HOME STREET, BOX 747 RUSHFORD, MN 55971**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 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. 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Good Shepherd Lutheran Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok FS 6-23-14 RECEIVED JUN 19 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 7-9-14

EXIT: 5-30-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas C Lindh — TITLE: Administrator — (X6) DATE: 6/17/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/27/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	**800 HOME STREET, BOX 747** **RUSHFORD, MN 55971**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Shepherd Lutheran Home is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1982, an addition was constructed and was determined to be of Type II(111) construction, with a partial basement. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is fully fire sprinklered. The facility has full corridor smoke detection, spaces open to the corridors and resident sleep rooms that is monitored for automatic fire department notification. The facility has a capacity of 75 beds and had a census of 72 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/27/2014

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		6/12/14
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 5-3.2.1. This deficient practice could affect all 72 residents. Findings include: On facility tour between 1:30 PM and 4:30 PM on 05/27/2014, the review of the 10 minute weekly fire pump run test logs and the week of 3/10/2014 test was missed. This deficient practice was confirmed by the Facility Maintenance Director (DF) at the time of discovery.	K 062	The fire pump run test logs will be monitored by Duane Franzwa, Director of maintenance. The fire pump test will be performed monthly per the Categorical Waivers Available information sheet (attached).	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/27/2014

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K 144	Continued From page 3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 72 residents. Findings include: On facility tour between 1:30 PM and 4:30 PM on 05/27/2014, documentation review of the weekly inspection logs (05/27/2013 to 05/27/2014) for the diesel emergency generator revealed that the weekly operational inspections were missed for the weeks of 2/3, 2/10 and 2/17/2014. This deficient practice was confirmed by the Director of Maintenance (DF) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144	Weekly inspection logs for the diesel/emergency generator will be monitored by Duane Franzwa Director of Maintenance to assure compliance.	6/12/14

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 Gary Schroeder **Date** 05/27/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00123	A. BUILDING: _____ B. WING _____	05/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

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2 000	Initial Comments *****ATTENTION****** 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. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On May 27, 28, 29 and 30 2014, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00123	A. BUILDING: _____ B. WING _____	05/30/2014

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2 000	Continued From page 1 Certification Program; 18 Wood Lake Drive SE, Rochester, MN 55904.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).	2 560		

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2 560	Continued From page 2 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: R34 had been admitted on 5/20/10. R34's admission record dated 5/29/14, identified diagnoses of chronic airway obstruction, congestive heart failure and hypertension. R34's physician orders dated 5/27/14, revealed orders for Advair (contains fluticasone a steroid and salmeterol a bronchodilator that works by relaxing muscles in the airways to improve breathing) 500/50 one puff by inhalation twice daily for chronic airway obstruction, DuoNeb (a sterile inhalation solution containing a combination of albuterol and ipratropium that are bronchodilators that relax muscles in the airways and increase air flow to the lungs) 2.5 mg (milligrams)/3 ml (milliliter) one vial by inhalation four times daily and every four hours as needed for chronic airway obstruction, losartan (a medication used to treat high blood pressure) 12.5 mg by mouth every day for hypertension and metoprolol XL (extended release) (a medication used to treat high blood pressure) 50 mg by mouth every day for hypertension. Document review of R34's medication administration record dated schedule for 5/14, revealed R34 had received Advair 500/50 one puff by inhalation twice daily, DuoNeb 2.5 mg/3	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 560	Continued From page 3 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. R34's care plan print date 5/29/14, had not addressed chronic airway obstruction or hypertension. During interview on 5/29/14, at 1:29 p.m., registered nurse (RN)-C had stated R34's care plan does not address chronic airway obstruction or hypertension. During interview on 5/29/14, at 1:36 p.m., RN-B had stated hypertension and chronic airway obstruction should probably be care planned if R34 is getting medications for the diagnoses. Document review of the facility GOOD SHEPARD LUTHERAN HOME POLICIES AND PROCEDURES NURSING CARE PLAN dated revised 11/15/12, read, "1. Assessment Each resident will be evaluated upon admission in the following areas: d. Medical problems - what problems are related to each diagnosis, medication and/or treatment. 2. Care Plan b. Problem/Needs A problem is defined as any significant deviation that has influenced, is now influencing, or may influence the resident ' s state of health or his/her ability to function normally. A need is defined as a condition requiring supply or relief... " SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate diagnoses along with medications. A monitoring program could be established in order to assure ongoing and effective care plans and interventions in response to resident care needs.	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 560	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 560		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 1 of 1 resident (R6) with contractures. Findings include: On 5/28/14 at 1:55 p.m., R6 was observed sitting in wheelchair in community area. R6 was unable to open right hand when asked. The fingers on R6' right hand was flexed into hand but fingers were moveable. R6 can move left hand/arm. R6 denied having pain when asked, shook head and pointed to right hand. R6 is unable to respond verbally to questions but does attempt to respond non-verbally by using left hand, head and vocal sounds. Surveyor observed R6 working with	2 570		

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2 570	Continued From page 5 Clinical Manager, (CM)-A. R6 could not open right hand, could not straighten wrist and displayed facial grimacing of pain. The Physician Evaluation document dated 4/29/14, lists current diagnoses of: right hemiparesis (paralysis), speechless, and expressive aphasia (language disturbance). The physician's order sheet signed on 4/19/14, gives orders for passive range of motion to right upper and both lower extremities 3 times a day, nights to incorporate range of motion during toileting and repositioning, every shift. Order start date was 9/24/10. R6's care plan did not address range of motion as ordered by the physician. Care plan dated 3/5/14 read, "I have occ [occasional] pain r/t [due to] muscles spasms/contractures." Also "I have limited physical mobility r/t right body paresis, contractures. Provide gentle range of motion as tolerated with daily care." During an interview with the director of nursing on 5/29/14 at 10:55 a.m. DON stated, "Yes, it should be on the care plan because it is a physician's order." SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff responsible for accuracy of care plans to add resident cares and services when a change is warranted. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 570		

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2 895	Continued From page 6	2 895		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion services as ordered by the physician and failed to assess the resident's need for range of motion and failed to revise the plan of care for 1 of 1 resident (R6) with contractures. Findings include: R6 was observed on 5/28/14 at 1:55 p.m., R6 and was sitting in wheelchair in the community area. R6 was unable to open right hand when asked. The fingers on R6' right hand was flexed into hand but fingers were moveable. R6 can move left hand/arm. R6 denied having pain when asked, shook head and pointed to right hand. R6 is unable to respond verbally to questions but does attempt to respond non-verbally by using left hand, head and vocal sounds. Surveyor observed R6 working with Clinical Manager	2 895		

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2 895	Continued From page 7 (CM)-A and again R6 could not open right hand, could not straighten wrist and also displayed facial grimacing of discomfort. The Physician Evaluation document dated 4/29/14, lists current diagnoses of: right hemiparesis (paralysis), speechless, and expressive aphasia (language disturbance). The physician's order sheet signed on 4/19/14, gives orders for passive range of motion to right upper and both lower extremities TID (3 times a day), nights to incorporate range of motion during toileting and repositioning, q shift (every shift). Order start date was 9/24/10. R6's current comprehensive care plan did not address range of motion services as ordered by the physician. Care plan dated 3/5/14 reads: "I have occ [occasional] pain r/t [due to] muscles spasms/contractures." also "I have limited physical mobility r/t right body paresis, contractures." And "Provide gentle range of motion as tolerated with daily care." POC (Point of Care) directions for nursing assistants (NA) included: passive range of motion exercises to right upper and both lower extremities, apply hamstring and heel cord stretches to both. QD (every day). During an interview on 5/28/14 at 2:00 p.m., NA-B stated that nursing does range of motion on the right side by stretching and moving fingers and also does range of motion to right leg daily. Stated it is done for 15 minutes and R6 tolerates it fair, has some discomfort but not pain. NA-B also stated if R6 did have pain during range of motion the resident would report it. NA-B stated R6 is not usually medicated before therapy and	2 895		

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2 895	Continued From page 8 also stated that she has not seen a change in R6's hand for 3 years. During an interview with RN-A on 5/28/14 at 2:24 p.m., the surveyor gave RN-A the current signed physician's orders for range of motion tid (3 times per day) and restorative nursing orders for daily and asked which was correct. RN-A stated, "Restorative orders should have been deleted, I must have forgotten to take it out " On 5/29/14 at 10:33 a.m., the trained medication assistant (TMA)-A who is the household manager stated that she communicates with RN-A, unit manager, regarding changes or concerns. When asked how R6 tolerates range of motion exercises TMA-A stated, "Not very well, she does have some discomfort. If she does, range of motion is stopped." Stated that the night shift does "gentle, relaxing range of motion." When asked by surveyor to clarify what that meant, TMA-A stated, "It is in the care plan." When asked if the nursing assistants have directions anywhere for what to do specifically for this resident for range of motion, TMA-A said, "No, everyone knows the residents pretty well. " During an interview with the Director of Nursing (DON) on 5/29/14 at 10:45 a.m., DON stated, R6 doesn't like range of motion so it is incorporated into her cares. When asked how often this was done, stated she wasn't sure. When asked what type of range of motion is done, she said," ankle." DON was asked if she was aware that orders for both restorative nursing and range of motion are still on the current physician order sheet and it is ordered to be done 3 times per day, and according to nursing assistant documentation range of motion is only being done daily or 2 times a day. The DON	2 895		

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2 895	Continued From page 9 stated she would have expected follow up from the nurse manger to find this discrepancy. DON stated that range of motion is not part of restorative nursing duties. During an interview with the DON On 5/29/14 at 10:55 a.m. the surveyor asked if range of motion should be on the care plan. The DON stated, "Yes, it should be on the care plan because it is a physician order." SUGGESTED METHOD FOR CORRECTION: The DON, director of therapy or designee(s) could review and revise as necessary the policies and procedures regarding implementing and maintaining proper range of motion care. The DON, director of therapy or designee(s) could provide an in-service for all appropriate staff on providing treatment per each resident ' s plan of care. The DON, director of therapy or designee(s) could monitor to assure residents receive proper range of motion treatment. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	2 895		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician	2 900		

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2 900	Continued From page 10 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: R80's admission record print date of 5/30/14, identified admitted on 12/6/13, diagnoses of heart failure, deficiency anemia, hypertension and edema. R80's 14 day Minimum Data Set (MDS) dated 1/4/14, identified at risk for pressure ulcer, skin treatment turning and repositioning program and application of dressing to feet, however stage one pressure ulcers to both heels had not been documented. Document review of R80's progress notes dated 12/30/13, at 3:56 a.m., identified skin/wound note: right heel red, approximately 3 cm (centimeters) and soft, assisted with repositioning, elevated heel off mattress and on 12/30/13, at 3:02 p.m., skin/wound note: impaired mobility, pressure, both heels red and soft, foam placed on bilaterally with Omnifix tape and wound nurse notified. No further skin/wound documentation had been noted in progress notes regarding pressure areas both heels after 12/30/13.	2 900		

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2 900	Continued From page 11 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. Document review of R80' s Braden Scale for predicting pressure sore risk revealed dates of assess 12/22/13 and 3/18/14. No assessment had been completed after development of pressure areas to both heels on 12/30/13. R80's checklist for skin risk factors and interventions revealed dates of completion of 12/11/13, admit comments: skin is intact, bruising and discoloration but no open areas, 12/22/13, hospital return comments: skin is intact, 3/18/14, quarterly review comments: Braden equals 20, skin intact and identified other risk factors cognitively impaired, assist with activities of daily living, cardiovascular disease heart failure, tissue tolerance and lower extremity concerns edema. Braden assessment interventions: moisture concerns: keep skin clean and dry, peri care after each incontinent episode, friction and sheer concerns: keep linen dry and wrinkle free and other risk factors not on Braden: weekly skin assessment by licensed staff, moisturize dry skin. No assessment had been completed after development of pressure areas to both heels on 12/30/13. Document review of R80's skin assessment tool lying revealed date of completion 12/22/13-12/23/13, comments: abdomen bruising, edema to legs, no redness noted, but	2 900		

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2 900	Continued From page 12 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. Although R80's care plan print date 5/29/14, had addressed bilateral edema in the lower extremities there had been no other documentation in R80's care plan regarding interventions to prevent pressure areas from getting worse nor preventative measures to heal current stage I ulcer or prevent others from occurring. During interview on 5/29/13, at 8:36 a.m., registered nurse (RN)-A verified red area documented in progress note on 12/30/13, on both heels of R80 had been stage one pressure areas. RN-A stated I did not look at heels and there had been no documentation by the wound nurse regarding pressure areas on R80's heels. RN-A stated the physician or nurse practitioner and family had not been notified of the pressure areas on heels. RN-A stated the treatment for pressure areas on both heels had been discontinued on 2/4/14 when the pressure area on both heels had resolved. RN-A verified no assessments had been completed after the development of pressure ulcers on both heels of R80. RN-A verified R80's current care plan had no skin plan of care other than legs wrapped with ace wraps daily and that had been under congestive heart problem. RN-A had stated when looking at the treatment administration record for the month of 1/2014, (10 out of 16 days of treatment for both heels had no signatures of treatment being completed) I see what you are seeing RN-A said to the surveyor. During interview on 5/29/14, at 9:37 a.m., director	2 900		

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2 900	Continued From page 13 of nursing (DON) had stated facility pressure ulcer process: case manager, dietician, physician and family should be informed when pressure ulcer develops. DON had stated case manager would be expected to monitor unless open then wound nurse to step in and monitor. DON had stated pressure areas should be monitored weekly until resolved. DON had stated would expect treatment to be completed and signed for on the treatment record as set up to be done. DON verified R80's current care plan had no skin plan of care other than ace wraps under congestive heart failure and would expect R80's care plan to have skin plan of care due to previous history of pressure ulcers on heels. GOOD SHEPARD LUTHERAN SERVICES SKIN INTEGRITY/PRESSURE ULCER PROTOCOL SKIN CARE GUIDELINES dated revised 3/28/13, read, "Purpose: To provide a systemic approach and monitoring process for skin integrity/pressure ulcer care. To prevent pressure ulcer development by identifying each resident's risk factors and implementing appropriate preventative interventions for those risk factors. To identify and promote healing of pressure ulcers in an efficient and timely manner and prevent the development of additional pressure ulcers ... " SUGGESTED METHOD OF CORRECTION: The DON or designee could educate staff on conducting comprehensive skin assessments. The DON or designee could develop and implement policy and procedure regarding comprehensive assessments and care of pressure ulcers. Audits of assessments and care of pressure ulcers could be done routinely to ensure comprehensive assessments and care are provided to residents with pressure ulcers.	2 900		

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2 900	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 900		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure evidence of tuberculin skin test for 1 of 5 employees (EE-A) reviewed for tuberculin skin tests. Findings include: EE-A personal file lacked evidence of reading the results of the first step tuberculin skin test and lacked evidence of second step tuberculin skin	21426		

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21426	Continued From page 15 test. EE-A had hire date of 2/10/14, according to facililty New Hire Report, dated 5/27/14. Document review of facility Tuberculin skin testing form, revealed EE-A received the first step tuberculin skin test on 2/10/14. During telephone interview on 5/30/14, at 9:14 a.m., registered nurse (RN)-B verified EE-A had hire date of 2/10/14, received first step tuberculin skin test on 2/10/14, and verified EE-A's first shift of resident contact was 2/21/14. During telephone interview on 5/30/14, at 10:04 a.m., RN-B verified the facility was aware EE-A's personal file lacked evidence of results of first step tuberculin skin test and lacked evidence of second step tuberculin skin test. RN-B stated although the facility had attempted to have EE-A provide the skin test results, none had been provided. Document review of facility Tuberculosis Control Plan policy updated 11/12/13, revealed page 5, E. 1. Prior to assuming job responsibilities, all employees will have a two-step skin test for TB (tuberculosis) unless documentation of a previous positive reaction and treatment can be provided. Participation in TB screening is considered a condition of employment. Page 5, E. 4. Data on skin test conversions will be monitored monthly by Staff Development Coordinator. Employee TB test results will be recorded on the appropriate form and filed in the employee ' s employment file.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with	21530		

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21530	Continued From page 16 Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist	21530		

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21530	Continued From page 17 identified lack of documentation of effectiveness for as needed (PRN) psychotropic medications for 1 of 5 residents (R72) reviewed for unnecessary medications. Findings include: R72 received PRN psychotropic medications however; there was not consistent monitoring to determine if the psychotropic medication was effective and the pharmacist had not identified and reported this to the physician or the director of nursing. R72 was admitted to the facility on 4/4/14 with diagnoses including: dementia with behavioral disturbance, Alzheimer's disease and anxiety state per the face sheet. R72's current physician orders dated 4/24/14 included PRN orders for the following psychotropic medications of " Ativan 0.5 mg [milligrams] by mouth (PO) - TID [three times a day] PRN [as needed]." Review of the March, April and May 2014 medication administration record (MAR) showed R72 received PRN Ativan 31 times from 3/2/14 to 3/31/14. The facility did not document the effectiveness of the PRN Ativan 7 of the 31 times the medication was administered. R72 received PRN Ativan 40 times from 4/3/14 to 4/30/14. Again the facility did not document the effectiveness of the PRN Ativan 12 of the 40 times the medication was administered. R72 received PRN Ativan 5 times from 5/1/14 to 5/24/14. Again the facility did not document the effectiveness of the PRN Ativan 3 of 5 the times	21530		

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	00123	A. BUILDING: _____ B. WING _____	05/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 18 the medication was administered. During an interview on 5/29/14 at 7:40 a.m., registered nurse (RN)-A verified nursing was to document the effectiveness of the PRN psychotropic medication. RN-A verified as evidenced by the MAR and progress notes nursing did not consistently document the effectiveness of the PRN Ativan for R72. Review of the Administering Medications policies and Procedures- undated read, "PRN Medications: 1. When administering 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 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. 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 for R72.	21530		

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21530	Continued From page 19 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 on 5/29/14 at 12:48 p.m. the consultant pharmacist stated he would expect the facility to document the effectiveness of PRN psychotropic medications administered to residents. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the consultant pharmacist identifies drug irregularities including appropriate monitoring for efficacy of medications. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen	21535		

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21535	Continued From page 20 must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to document effectiveness for an as needed (PRN) psychotropic medication used for 1 of 5 residents (R72) reviewed for unnecessary medications and the facility failed to attempt a gradual dose reduction and titration of an antipsychotic and antidepressant medication after receiving these two medications for one year or provide a physician's justification why it is contraindicated at this time for 1 of 1 resident (15) who currently takes Abilify (antipsychotic) and Sertraline. Findings include:	21535		

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21535	Continued From page 21 R72 received PRN psychotropic medications however; there was not consistent monitoring to determine if the psychotropic medication was effective and the pharmacist had not identified and reported this to the physician or the director of nursing. R72 was admitted to the facility on 4/4/14 with diagnoses including: dementia with behavioral disturbance, Alzheimer's disease and anxiety state per the face sheet. R72's current physician orders dated 4/24/14 included PRN orders for the following psychotropic medications of "Ativan 0.5 mg [milligrams] by mouth (PO) - TID [three times a day] PRN [as needed]." Review of the March, April and May 2014 medication administration record (MAR) showed R72 received PRN Ativan 31 times from 3/2/14 to 3/31/14. The facility did not document the effectiveness of the PRN Ativan 7 of the 31 times the medication was administered. R72 received PRN Ativan 40 times from 4/3/14 to 4/30/14. Again the facility did not document the effectiveness of the PRN Ativan 12 of the 40 times the medication was administered. R72 received PRN Ativan 5 times from 5/1/14 to 5/24/14. Again the facility did not document the effectiveness of the PRN Ativan 3 of 5 the times the medication was administered. During an interview on 5/29/14 at 7:40 a.m., registered nurse (RN)-A verified nursing was to document the effectiveness of the PRN psychotropic medication. RN-A verified as evidenced by the MAR and progress notes	21535		

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21535	Continued From page 22 nursing did not consistently document the effectiveness of the PRN Ativan for R72. Review of the Administering Medications policies and Procedures- undated read, "PRN Medications: 1. When administering 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 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. 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 for R72. R15 received daily dose of an antipsychotic medication and an antidepressant for the past year and a gradual dose reduction (GDR) or a medication titration had been attempted or had a physician ' s justification as to why the GDR and titration was contraindicated at this time	21535		

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21535	Continued From page 23 completed. On 5/28/14 at 2:45 p.m., R15 was observed lying in bed in room doing a puzzle. R15 was alert and able to respond to questions and stated she was just taking an afternoon rest. R15 initiated conversation and stated she is battling a cold and sore throat. 5/29/14 at 7:40 a.m., R15 was observed in room lying in bed and stated she just woke up but was going back to sleep as she usually sleeps until 10:00 a.m. Physician notes from 3/12/14 lists diagnoses of: degenerative joint disease, cva (stroke), hip pain, morbid obesity, hypertension, chronic kidney disease, Factor V Leiden deficiency (blood condition), anemia, depression, and renal cyst. Review of Behavior Monitoring Book on 5/29/14 indicates monitoring for depression symptoms is being done and interventions are listed. R15's physician order sheet for May 2014 has orders for Abilify (antipsychotic) 5 mg per day and Sertraline (antidepressant) 150 mg every day. A progress note was made by the Consultant Pharmacist on 4/23/14 recommending a dose reduction for Abilify or use of the Antipsychotic Dosing and Gradual Reduction Form to document rationale for not attempting a dose reduction. The form was completed on 5/6/14, but documentation did not comply with the recommended guidelines listed in the pharmacy consultant ' s progress note. The Antidepressant Gradual Reduction Form was completed on 11/14/12 and 5/6/14 but dosage reduction has not been attempted. The facility's Antipsychotic	21535		

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21535	Continued From page 24 Medication Quarterly Evaluation form indicates that a gradual dose reduction of psychoactive medications should be attempted after the resident has been on an antipsychotic not more than 6 months. During an interview on 5/29/14 at 9:15 a.m., director of nursing (DON) was asked for policy and procedure for monitoring psychoactive medications and dose reduction. DON stated quantative charting is done by the nurse managers and stated there is no policy for psychoactive medications and dose reduction. SUGGESTED METHOD OF CORRECTION: The director of nursing or pharmacist could in-service all staff responsible for medication use on the need to meet the requirements as written under this licensing order. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21535		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 5 of 10 resident (R49, R26, R54, R15, R16) wheelchairs were in a state of good repair. Findings include:	21665		

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21665	Continued From page 25 During interview on 5/29/14, at 10:05 a.m., maintenance (M)-A stated the facility system was for the nursing department to complete a " Maintenance Work Request" a pink slip to notify maintenance department when there was a problem with safety concerns or repairs were needed. M-A stated there were three maintenance staff in the facility. M-A stated maintenance made repairs as soon as they were notified. During interview at that time, maintenance-B and Maintenance-C verified they had no wheelchair repair requests. During interview on 5/29/14, at 1:08 p.m., licensed social worker (LSW)-A stated the facility had no policy for maintenance notification for repairs. LSW-A stated facility standard of practice was to notify maintenance when repairs were needed, by completing a maintenance work order slip. R49's wheelchair arm rests and back of chair had cracked vinyl which was rough to the touch not a cleanable surface. During observations on 5/28/14, at 1:30 p.m., R49 sat in a lounge chair in the facility lobby with wheelchair beside the chair. Observations at that time, revealed the wheelchair right arm rest had cracked and missing vinyl with cloth exposed. During observations on 5/29/14, at 7:25 a.m., as R49 received morning cares, wheelchair sat at the foot of the bed. Observations at that time revealed right arm rest of wheelchair cracked and missing vinyl with cloth exposed, left arm rest of wheelchair with small area of cracked vinyl, and large area of back of wheelchair which would come in contact with resident, vinyl cracked and	21665		

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21665	Continued From page 26 missing with cloth exposed. During interview at that time, R49 stated he took the wheelchair to medical appointments three times a week. R49 stated he " really wished " the facility would find him another wheelchair. R49 stated he had scratched his arms on the rough vinyl. During interview on 5/29/14, at 8:05 a.m., licensed practical nurse (LPN)-A verified the cracked vinyl and exposed cloth on both wheelchair arm rests and back of wheelchair. LPN-A stated the facility needed to replace the vinyl. During observations at that time, R49 held up both arms to reveal no scratches at present. R26 was identified on the quarterly Minimum Data Set (MDS), an assessment dated 3/11/14, to have moderate cognitive impairment, used mobility device of wheelchair and walker, and required extensive assistance of 1 staff for locomotion on and off unit. Document review of facility resident care plan dated 2/17/14, directed staff R26, was able to wheel self-short distance but required staff to wheel to destinations. During observations on 5/29/14, at 10:00 a.m., R26 was in bed with wheelchair by the bedside. Observations at that time revealed R26 ' s wheelchair outer left arm rest had cracked vinyl and upper back of wheelchair which would come in contact with resident had cracked and missing vinyl with cloth exposed. During interview at that time, R26 stated the cracked vinyl had not scratched her arms. 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	21665		

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21665	Continued From page 27	21665		

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.

R54 was observed on 5/29/14, at 1:00 p.m., R54 was sitting in wheelchair in hallway. R54's wheelchair had cracks and pieces of vinyl missing. Licensed Practical Nurse (LPN)-A was interviewed at 1:40 p.m., and stated that she was not aware of the wheelchair arm issue and stated that housekeeping is responsible for cleaning the chair and both nursing and housekeeping can report issues to maintenance.

Document review of R54's care plan dated 2/12/14, indicated that R54 uses a wheelchair for long distances and requires assistance of 1 staff. Care plan identifies diagnoses of Dementia and short term memory impairment.

R15 was observed on 5/29/14, R15 was sitting in wheelchair in room. Left armrest was cracked and pieces of vinyl were missing. R15 stated that the arm rest does scratch her arm. No scratches or alterations in skin noted at that time. At 1:00 p.m., Registered Nurse (RN)-C was interviewed and stated she was unaware of the wheelchair issue and stated that staff is supposed to alert the Nurse Manager so they can notify maintenance.

Document review of R 15's care plan, dated 4/11/14, identifies a deficit in ADL's (activities of daily living). Interventions included: "Skin Inspection: I would like my SKIN inspected daily. Observe for redness, open areas, scratches, 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

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21665	Continued From page 28 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. Document review of R16's care plan dated 5/2/2014, indicated that R16 has the potential for alteration in skin integrity and interventions directed staff to monitor skin condition, report any redness or irritation and apply moisturizer as needed. Care plan also addresses use of Coumadin (blood thinner) and interventions included, "Cares are done gently and skin is observed for any alteration. I have a higher level of mobility; independent with wheelchair mobility/walking so my activity also puts me at higher risk for bruising." SUGGESTED METHOD OF CORRECTION: The maintenance department could include a visual inspection of residents wheelchairs house wide to ensure wheelchairs were in good repair and cleanable. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21665		

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2 000	Initial Comments *****ATTENTION****** 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. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On May 27, 28, 29 and 30 2014, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Certification Program; 18 Wood Lake Drive SE, Rochester, MN 55904.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).	2 560		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 2 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: R34 had been admitted on 5/20/10. R34's admission record dated 5/29/14, identified diagnoses of chronic airway obstruction, congestive heart failure and hypertension. R34's physician orders dated 5/27/14, revealed orders for Advair (contains fluticasone a steroid and salmeterol a bronchodilator that works by relaxing muscles in the airways to improve breathing) 500/50 one puff by inhalation twice daily for chronic airway obstruction, DuoNeb (a sterile inhalation solution containing a combination of albuterol and ipratropium that are bronchodilators that relax muscles in the airways and increase air flow to the lungs) 2.5 mg (milligrams)/3 ml (milliliter) one vial by inhalation four times daily and every four hours as needed for chronic airway obstruction, losartan (a medication used to treat high blood pressure) 12.5 mg by mouth every day for hypertension and metoprolol XL (extended release) (a medication used to treat high blood pressure) 50 mg by mouth every day for hypertension. Document review of R34's medication administration record dated schedule for 5/14, revealed R34 had received Advair 500/50 one puff by inhalation twice daily, DuoNeb 2.5 mg/3	2 560		

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	00123	A. BUILDING: _____ B. WING _____	05/30/2014

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2 560	Continued From page 3 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. R34's care plan print date 5/29/14, had not addressed chronic airway obstruction or hypertension. During interview on 5/29/14, at 1:29 p.m., registered nurse (RN)-C had stated R34's care plan does not address chronic airway obstruction or hypertension. During interview on 5/29/14, at 1:36 p.m., RN-B had stated hypertension and chronic airway obstruction should probably be care planned if R34 is getting medications for the diagnoses. Document review of the facility GOOD SHEPARD LUTHERAN HOME POLICIES AND PROCEDURES NURSING CARE PLAN dated revised 11/15/12, read, "1. Assessment Each resident will be evaluated upon admission in the following areas: d. Medical problems - what problems are related to each diagnosis, medication and/or treatment. 2. Care Plan b. Problem/Needs A problem is defined as any significant deviation that has influenced, is now influencing, or may influence the resident ' s state of health or his/her ability to function normally. A need is defined as a condition requiring supply or relief... " SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate diagnoses along with medications. A monitoring program could be established in order to assure ongoing and effective care plans and interventions in response to resident care needs.	2 560		

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2 560	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 560		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 1 of 1 resident (R6) with contractures. Findings include: On 5/28/14 at 1:55 p.m., R6 was observed sitting in wheelchair in community area. R6 was unable to open right hand when asked. The fingers on R6' right hand was flexed into hand but fingers were moveable. R6 can move left hand/arm. R6 denied having pain when asked, shook head and pointed to right hand. R6 is unable to respond verbally to questions but does attempt to respond non-verbally by using left hand, head and vocal sounds. Surveyor observed R6 working with	2 570		

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2 570	Continued From page 5 Clinical Manager, (CM)-A. R6 could not open right hand, could not straighten wrist and displayed facial grimacing of pain. The Physician Evaluation document dated 4/29/14, lists current diagnoses of: right hemiparesis (paralysis), speechless, and expressive aphasia (language disturbance). The physician's order sheet signed on 4/19/14, gives orders for passive range of motion to right upper and both lower extremities 3 times a day, nights to incorporate range of motion during toileting and repositioning, every shift. Order start date was 9/24/10. R6's care plan did not address range of motion as ordered by the physician. Care plan dated 3/5/14 read, "I have occ [occasional] pain r/t [due to] muscles spasms/contractures." Also "I have limited physical mobility r/t right body paresis, contractures. Provide gentle range of motion as tolerated with daily care." During an interview with the director of nursing on 5/29/14 at 10:55 a.m. DON stated, "Yes, it should be on the care plan because it is a physician's order." SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff responsible for accuracy of care plans to add resident cares and services when a change is warranted. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 570		

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2 895	Continued From page 6	2 895		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion services as ordered by the physician and failed to assess the resident's need for range of motion and failed to revise the plan of care for 1 of 1 resident (R6) with contractures. Findings include: R6 was observed on 5/28/14 at 1:55 p.m., R6 and was sitting in wheelchair in the community area. R6 was unable to open right hand when asked. The fingers on R6' right hand was flexed into hand but fingers were moveable. R6 can move left hand/arm. R6 denied having pain when asked, shook head and pointed to right hand. R6 is unable to respond verbally to questions but does attempt to respond non-verbally by using left hand, head and vocal sounds. Surveyor observed R6 working with Clinical Manager	2 895		

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2 895	Continued From page 7 (CM)-A and again R6 could not open right hand, could not straighten wrist and also displayed facial grimacing of discomfort. The Physician Evaluation document dated 4/29/14, lists current diagnoses of: right hemiparesis (paralysis), speechless, and expressive aphasia (language disturbance). The physician's order sheet signed on 4/19/14, gives orders for passive range of motion to right upper and both lower extremities TID (3 times a day), nights to incorporate range of motion during toileting and repositioning, q shift (every shift). Order start date was 9/24/10. R6's current comprehensive care plan did not address range of motion services as ordered by the physician. Care plan dated 3/5/14 reads: "I have occ [occasional] pain r/t [due to] muscles spasms/contractures." also "I have limited physical mobility r/t right body paresis, contractures." And "Provide gentle range of motion as tolerated with daily care." POC (Point of Care) directions for nursing assistants (NA) included: passive range of motion exercises to right upper and both lower extremities, apply hamstring and heel cord stretches to both. QD (every day). During an interview on 5/28/14 at 2:00 p.m., NA-B stated that nursing does range of motion on the right side by stretching and moving fingers and also does range of motion to right leg daily. Stated it is done for 15 minutes and R6 tolerates it fair, has some discomfort but not pain. NA-B also stated if R6 did have pain during range of motion the resident would report it. NA-B stated R6 is not usually medicated before therapy and	2 895		

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2 895	Continued From page 8 also stated that she has not seen a change in R6's hand for 3 years. During an interview with RN-A on 5/28/14 at 2:24 p.m., the surveyor gave RN-A the current signed physician's orders for range of motion tid (3 times per day) and restorative nursing orders for daily and asked which was correct. RN-A stated, "Restorative orders should have been deleted, I must have forgotten to take it out " On 5/29/14 at 10:33 a.m., the trained medication assistant (TMA)-A who is the household manager stated that she communicates with RN-A, unit manager, regarding changes or concerns. When asked how R6 tolerates range of motion exercises TMA-A stated, "Not very well, she does have some discomfort. If she does, range of motion is stopped." Stated that the night shift does "gentle, relaxing range of motion." When asked by surveyor to clarify what that meant, TMA-A stated, "It is in the care plan." When asked if the nursing assistants have directions anywhere for what to do specifically for this resident for range of motion, TMA-A said, "No, everyone knows the residents pretty well. " During an interview with the Director of Nursing (DON) on 5/29/14 at 10:45 a.m., DON stated, R6 doesn't like range of motion so it is incorporated into her cares. When asked how often this was done, stated she wasn't sure. When asked what type of range of motion is done, she said," ankle." DON was asked if she was aware that orders for both restorative nursing and range of motion are still on the current physician order sheet and it is ordered to be done 3 times per day, and according to nursing assistant documentation range of motion is only being done daily or 2 times a day. The DON	2 895		

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2 895	Continued From page 9 stated she would have expected follow up from the nurse manger to find this discrepancy. DON stated that range of motion is not part of restorative nursing duties. During an interview with the DON On 5/29/14 at 10:55 a.m. the surveyor asked if range of motion should be on the care plan. The DON stated, "Yes, it should be on the care plan because it is a physician order." SUGGESTED METHOD FOR CORRECTION: The DON, director of therapy or designee(s) could review and revise as necessary the policies and procedures regarding implementing and maintaining proper range of motion care. The DON, director of therapy or designee(s) could provide an in-service for all appropriate staff on providing treatment per each resident ' s plan of care. The DON, director of therapy or designee(s) could monitor to assure residents receive proper range of motion treatment. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	2 895		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician	2 900		

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2 900	Continued From page 10 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: R80's admission record print date of 5/30/14, identified admitted on 12/6/13, diagnoses of heart failure, deficiency anemia, hypertension and edema. R80's 14 day Minimum Data Set (MDS) dated 1/4/14, identified at risk for pressure ulcer, skin treatment turning and repositioning program and application of dressing to feet, however stage one pressure ulcers to both heels had not been documented. Document review of R80's progress notes dated 12/30/13, at 3:56 a.m., identified skin/wound note: right heel red, approximately 3 cm (centimeters) and soft, assisted with repositioning, elevated heel off mattress and on 12/30/13, at 3:02 p.m., skin/wound note: impaired mobility, pressure, both heels red and soft, foam placed on bilaterally with Omnifix tape and wound nurse notified. No further skin/wound documentation had been noted in progress notes regarding pressure areas both heels after 12/30/13.	2 900		

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2 900	Continued From page 11 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. Document review of R80' s Braden Scale for predicting pressure sore risk revealed dates of assess 12/22/13 and 3/18/14. No assessment had been completed after development of pressure areas to both heels on 12/30/13. R80's checklist for skin risk factors and interventions revealed dates of completion of 12/11/13, admit comments: skin is intact, bruising and discoloration but no open areas, 12/22/13, hospital return comments: skin is intact, 3/18/14, quarterly review comments: Braden equals 20, skin intact and identified other risk factors cognitively impaired, assist with activities of daily living, cardiovascular disease heart failure, tissue tolerance and lower extremity concerns edema. Braden assessment interventions: moisture concerns: keep skin clean and dry, peri care after each incontinent episode, friction and sheer concerns: keep linen dry and wrinkle free and other risk factors not on Braden: weekly skin assessment by licensed staff, moisturize dry skin. No assessment had been completed after development of pressure areas to both heels on 12/30/13. Document review of R80's skin assessment tool lying revealed date of completion 12/22/13-12/23/13, comments: abdomen bruising, edema to legs, no redness noted, but	2 900		

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2 900	Continued From page 12 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. Although R80's care plan print date 5/29/14, had addressed bilateral edema in the lower extremities there had been no other documentation in R80's care plan regarding interventions to prevent pressure areas from getting worse nor preventative measures to heal current stage I ulcer or prevent others from occurring. During interview on 5/29/13, at 8:36 a.m., registered nurse (RN)-A verified red area documented in progress note on 12/30/13, on both heels of R80 had been stage one pressure areas. RN-A stated I did not look at heels and there had been no documentation by the wound nurse regarding pressure areas on R80's heels. RN-A stated the physician or nurse practitioner and family had not been notified of the pressure areas on heels. RN-A stated the treatment for pressure areas on both heels had been discontinued on 2/4/14 when the pressure area on both heels had resolved. RN-A verified no assessments had been completed after the development of pressure ulcers on both heels of R80. RN-A verified R80's current care plan had no skin plan of care other than legs wrapped with ace wraps daily and that had been under congestive heart problem. RN-A had stated when looking at the treatment administration record for the month of 1/2014, (10 out of 16 days of treatment for both heels had no signatures of treatment being completed) I see what you are seeing RN-A said to the surveyor. During interview on 5/29/14, at 9:37 a.m., director	2 900		

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2 900	Continued From page 13 of nursing (DON) had stated facility pressure ulcer process: case manager, dietician, physician and family should be informed when pressure ulcer develops. DON had stated case manager would be expected to monitor unless open then wound nurse to step in and monitor. DON had stated pressure areas should be monitored weekly until resolved. DON had stated would expect treatment to be completed and signed for on the treatment record as set up to be done. DON verified R80's current care plan had no skin plan of care other than ace wraps under congestive heart failure and would expect R80's care plan to have skin plan of care due to previous history of pressure ulcers on heels. GOOD SHEPARD LUTHERAN SERVICES SKIN INTEGRITY/PRESSURE ULCER PROTOCOL SKIN CARE GUIDELINES dated revised 3/28/13, read, "Purpose: To provide a systemic approach and monitoring process for skin integrity/pressure ulcer care. To prevent pressure ulcer development by identifying each resident's risk factors and implementing appropriate preventative interventions for those risk factors. To identify and promote healing of pressure ulcers in an efficient and timely manner and prevent the development of additional pressure ulcers ... " SUGGESTED METHOD OF CORRECTION: The DON or designee could educate staff on conducting comprehensive skin assessments. The DON or designee could develop and implement policy and procedure regarding comprehensive assessments and care of pressure ulcers. Audits of assessments and care of pressure ulcers could be done routinely to ensure comprehensive assessments and care are provided to residents with pressure ulcers.	2 900		

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2 900	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 900		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure evidence of tuberculin skin test for 1 of 5 employees (EE-A) reviewed for tuberculin skin tests. Findings include: EE-A personal file lacked evidence of reading the results of the first step tuberculin skin test and lacked evidence of second step tuberculin skin	21426		

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21426	Continued From page 15 test. EE-A had hire date of 2/10/14, according to facililty New Hire Report, dated 5/27/14. Document review of facility Tuberculin skin testing form, revealed EE-A received the first step tuberculin skin test on 2/10/14. During telephone interview on 5/30/14, at 9:14 a.m., registered nurse (RN)-B verified EE-A had hire date of 2/10/14, received first step tuberculin skin test on 2/10/14, and verified EE-A's first shift of resident contact was 2/21/14. During telephone interview on 5/30/14, at 10:04 a.m., RN-B verified the facility was aware EE-A's personal file lacked evidence of results of first step tuberculin skin test and lacked evidence of second step tuberculin skin test. RN-B stated although the facility had attempted to have EE-A provide the skin test results, none had been provided. Document review of facility Tuberculosis Control Plan policy updated 11/12/13, revealed page 5, E. 1. Prior to assuming job responsibilities, all employees will have a two-step skin test for TB (tuberculosis) unless documentation of a previous positive reaction and treatment can be provided. Participation in TB screening is considered a condition of employment. Page 5, E. 4. Data on skin test conversions will be monitored monthly by Staff Development Coordinator. Employee TB test results will be recorded on the appropriate form and filed in the employee's employment file. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service employees responsible for giving and monitoring TB status of new employees the current standard for giving TB. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

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21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.	21530		

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21530	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist identified lack of documentation of effectiveness for as needed (PRN) psychotropic medications for 1 of 5 residents (R72) reviewed for unnecessary medications. Findings include: R72 received PRN psychotropic medications however; there was not consistent monitoring to determine if the psychotropic medication was effective and the pharmacist had not identified and reported this to the physician or the director of nursing. R72 was admitted to the facility on 4/4/14 with diagnoses including: dementia with behavioral disturbance, Alzheimer's disease and anxiety state per the face sheet. R72's current physician orders dated 4/24/14 included PRN orders for the following psychotropic medications of " Ativan 0.5 mg [milligrams] by mouth (PO) - TID [three times a day] PRN [as needed]." Review of the March, April and May 2014 medication administration record (MAR) showed R72 received PRN Ativan 31 times from 3/2/14 to 3/31/14. The facility did not document the effectiveness of the PRN Ativan 7 of the 31 times the medication was administered. R72 received PRN Ativan 40 times from 4/3/14 to 4/30/14. Again the facility did not document the	21530		

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21530	Continued From page 18 effectiveness of the PRN Ativan 12 of the 40 times the medication was administered. R72 received PRN Ativan 5 times from 5/1/14 to 5/24/14. Again the facility did not document the effectiveness of the PRN Ativan 3 of 5 the times the medication was administered. During an interview on 5/29/14 at 7:40 a.m., registered nurse (RN)-A verified nursing was to document the effectiveness of the PRN psychotropic medication. RN-A verified as evidenced by the MAR and progress notes nursing did not consistently document the effectiveness of the PRN Ativan for R72. Review of the Administering Medications policies and Procedures- undated read, "PRN Medications: 1. When administering 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 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	21530		

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21530	Continued From page 19 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 for R72. 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 on 5/29/14 at 12:48 p.m. the consultant pharmacist stated he would expect the facility to document the effectiveness of PRN psychotropic medications administered to residents. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the consultant pharmacist identifies drug irregularities including appropriate monitoring for efficacy of medications. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21530		

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21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to document effectiveness for an as needed (PRN) psychotropic medication used for 1 of 5 residents (R72) reviewed for unnecessary medications and the facility failed to attempt a gradual dose reduction and titration of an antipsychotic and antidepressant medication after receiving these two medications for one year or provide a physician's justification why it is contraindicated at this time for 1 of 1 resident (15)	21535		

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21535	Continued From page 21 who currently takes Abilify (antipsychotic) and Sertraline. Findings include: R72 received PRN psychotropic medications however; there was not consistent monitoring to determine if the psychotropic medication was effective and the pharmacist had not identified and reported this to the physician or the director of nursing. R72 was admitted to the facility on 4/4/14 with diagnoses including: dementia with behavioral disturbance, Alzheimer's disease and anxiety state per the face sheet. R72's current physician orders dated 4/24/14 included PRN orders for the following psychotropic medications of "Ativan 0.5 mg [milligrams] by mouth (PO) - TID [three times a day] PRN [as needed]." Review of the March, April and May 2014 medication administration record (MAR) showed R72 received PRN Ativan 31 times from 3/2/14 to 3/31/14. The facility did not document the effectiveness of the PRN Ativan 7 of the 31 times the medication was administered. R72 received PRN Ativan 40 times from 4/3/14 to 4/30/14. Again the facility did not document the effectiveness of the PRN Ativan 12 of the 40 times the medication was administered. R72 received PRN Ativan 5 times from 5/1/14 to 5/24/14. Again the facility did not document the effectiveness of the PRN Ativan 3 of 5 the times the medication was administered. During an interview on 5/29/14 at 7:40 a.m.,	21535		

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21535	Continued From page 22 registered nurse (RN)-A verified nursing was to document the effectiveness of the PRN psychotropic medication. RN-A verified as evidenced by the MAR and progress notes nursing did not consistently document the effectiveness of the PRN Ativan for R72. Review of the Administering Medications policies and Procedures- undated read, "PRN Medications: 1. When administering 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 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. 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 for R72. R15 received daily dose of an antipsychotic medication and an antidepressant for the past	21535		

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21535	Continued From page 23	21535		

year and a gradual dose reduction (GDR) or a medication titration had been attempted or had a physician ' s justification as to why the GDR and titration was contraindicated at this time completed.

On 5/28/14 at 2:45 p.m., R15 was observed lying in bed in room doing a puzzle. R15 was alert and able to respond to questions and stated she was just taking an afternoon rest. R15 initiated conversation and stated she is battling a cold and sore throat.

5/29/14 at 7:40 a.m., R15 was observed in room lying in bed and stated she just woke up but was going back to sleep as she usually sleeps until 10:00 a.m.

Physician notes from 3/12/14 lists diagnoses of: degenerative joint disease, cva (stroke), hip pain, morbid obesity, hypertension, chronic kidney disease, Factor V Leiden deficiency (blood condition), anemia, depression, and renal cyst.

Review of Behavior Monitoring Book on 5/29/14 indicates monitoring for depression symptoms is being done and interventions are listed.

R15's physician order sheet for May 2014 has orders for Abilify (antipsychotic) 5 mg per day and Sertraline (antidepressant) 150 mg every day.

A progress note was made by the Consultant Pharmacist on 4/23/14 recommending a dose reduction for Abilify or use of the Antipsychotic Dosing and Gradual Reduction Form to document rationale for not attempting a dose reduction. The form was completed on 5/6/14, but documentation did not comply with the recommended guidelines listed in the pharmacy

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21535	Continued From page 24 consultant ' s progress note. The Antidepressant Gradual Reduction Form was completed on 11/14/12 and 5/6/14 but dosage reduction has not been attempted. The facility's Antipsychotic Medication Quarterly Evaluation form indicates that a gradual dose reduction of psychoactive medications should be attempted after the resident has been on an antipsychotic not more than 6 months. During an interview on 5/29/14 at 9:15 a.m., director of nursing (DON) was asked for policy and procedure for monitoring psychoactive medications and dose reduction. DON stated quantative charting is done by the nurse managers and stated there is no policy for psychoactive medications and dose reduction. SUGGESTED METHOD OF CORRECTION: The director of nursing or pharmacist could in-service all staff responsible for medication use on the need to meet the requirements as written under this licensing order. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21535		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 5 of 10	21665		

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21665	Continued From page 25 resident (R49, R26, R54, R15, R16) wheelchairs were in a state of good repair. Findings include: During interview on 5/29/14, at 10:05 a.m., maintenance (M)-A stated the facility system was for the nursing department to complete a " Maintenance Work Request" a pink slip to notify maintenance department when there was a problem with safety concerns or repairs were needed. M-A stated there were three maintenance staff in the facility. M-A stated maintenance made repairs as soon as they were notified. During interview at that time, maintenance-B and Maintenance-C verified they had no wheelchair repair requests. During interview on 5/29/14, at 1:08 p.m., licensed social worker (LSW)-A stated the facility had no policy for maintenance notification for repairs. LSW-A stated facility standard of practice was to notify maintenance when repairs were needed, by completing a maintenance work order slip. R49's wheelchair arm rests and back of chair had cracked vinyl which was rough to the touch not a cleanable surface. During observations on 5/28/14, at 1:30 p.m., R49 sat in a lounge chair in the facility lobby with wheelchair beside the chair. Observations at that time, revealed the wheelchair right arm rest had cracked and missing vinyl with cloth exposed. During observations on 5/29/14, at 7:25 a.m., as R49 received morning cares, wheelchair sat at the foot of the bed. Observations at that time revealed right arm rest of wheelchair cracked and	21665		

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21665	Continued From page 26 missing vinyl with cloth exposed, left arm rest of wheelchair with small area of cracked vinyl, and large area of back of wheelchair which would come in contact with resident, vinyl cracked and missing with cloth exposed. During interview at that time, R49 stated he took the wheelchair to medical appointments three times a week. R49 stated he " really wished " the facility would find him another wheelchair. R49 stated he had scratched his arms on the rough vinyl. During interview on 5/29/14, at 8:05 a.m., licensed practical nurse (LPN)-A verified the cracked vinyl and exposed cloth on both wheelchair arm rests and back of wheelchair. LPN-A stated the facility needed to replace the vinyl. During observations at that time, R49 held up both arms to reveal no scratches at present. R26 was identified on the quarterly Minimum Data Set (MDS), an assessment dated 3/11/14, to have moderate cognitive impairment, used mobility device of wheelchair and walker, and required extensive assistance of 1 staff for locomotion on and off unit. Document review of facility resident care plan dated 2/17/14, directed staff R26, was able to wheel self-short distance but required staff to wheel to destinations. During observations on 5/29/14, at 10:00 a.m., R26 was in bed with wheelchair by the bedside. Observations at that time revealed R26 ' s wheelchair outer left arm rest had cracked vinyl and upper back of wheelchair which would come in contact with resident had cracked and missing vinyl with cloth exposed. During interview at that time, R26 stated the cracked vinyl had not scratched her arms.	21665		

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21665	Continued From page 27 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. R54 was observed on 5/29/14, at 1:00 p.m., R54 was sitting in wheelchair in hallway. R54's wheelchair had cracks and pieces of vinyl missing. Licensed Practical Nurse (LPN)-A was interviewed at 1:40 p.m., and stated that she was not aware of the wheelchair arm issue and stated that housekeeping is responsible for cleaning the chair and both nursing and housekeeping can report issues to maintenance. Document review of R54's care plan dated 2/12/14, indicated that R54 uses a wheelchair for long distances and requires assistance of 1 staff. Care plan identifies diagnoses of Dementia and short term memory impairment. R15 was observed on 5/29/14, R15 was sitting in wheelchair in room. Left armrest was cracked and pieces of vinyl were missing. R15 stated that the arm rest does scratch her arm. No scratches or alterations in skin noted at that time. At 1:00 p.m., Registered Nurse (RN)-C was interviewed and stated she was unaware of the wheelchair issue and stated that staff is supposed to alert the Nurse Manager so they can notify maintenance. Document review of R 15's care plan, dated 4/11/14, identifies a deficit in ADL's (activities of daily living). Interventions included: "Skin Inspection: I would like my SKIN inspected daily. Observe for redness, open areas, scratches,	21665		

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21665	Continued From page 28 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. Document review of R16's care plan dated 5/2/2014, indicated that R16 has the potential for alteration in skin integrity and interventions directed staff to monitor skin condition, report any redness or irritation and apply moisturizer as needed. Care plan also addresses use of Coumadin (blood thinner) and interventions included, "Cares are done gently and skin is observed for any alteration. I have a higher level of mobility; independent with wheelchair mobility/walking so my activity also puts me at higher risk for bruising." SUGGESTED METHOD OF CORRECTION: The maintenance department could include a visual inspection of residents wheelchairs house wide to ensure wheelchairs were in good repair and cleanable. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21665		